CATASTROPHIC ILLNESS EXPENSES

Department of Health and Human Services Report to the President

DEPARTMENT OF HEALTH & HUMAN SERVICES

November 1986

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

November 19, 1986

Dear Mr. President:

As a physician, I have seen the spirit of many families broken not only by the anguish of a disease, but by the overwhelming weight of the financial burden the illness has brought.

In your State of the Union address in February, you offered me the unique opportunity to provide recommendations on how the private sector and Government can work together to address the problems of affordable insurance for those whose life savings would be otherwise threatened when catastrophic illness strikes.

It has been a difficult challenge, but one I was pleased to undertake. Therefore, I submit the Department of Health and Human Services' Report on Catastrophic Illness Expenses.

It is my greatest hope that this report will mark the beginning of an era when devastating illness will no longer destroy the financial security of American families.

Respectfully,

Otis R. Bowen M.D.

Otis R. Bowen, M.D.
Secretary

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EXECUTIVE SUMMARY

The American health care system provides substantial benefits to most Americans. Even so, many Americans run the risk of financial ruin when catastrophic illness strikes. The President, in his 1986 State of the Union address, requested a study of how the private sector and government can work together to address this problem.

No single policy approach provides protection for all groups of people and for all types of health expenses; but a combination of options can help reduce the financial risks for many people. Options are available to redirect government health financing programs, to encourage private saving and the purchase of private insurance, and to stimulate development of innovative methods of providing health care services by the private sector.

Current Coverage and Risk Patterns

Almost all Americans have some health insurance -- virtually all of the elderly (with Medicare and two-thirds with supplementary Medigap insurance as well), and nine out of ten members of the general population. In addition, a wide variety of subsidized or free health services are provided to individuals through public and private hospitals, clinics, and other health care programs. Some of these are sponsored by State and local governments, some by private nonprofit organizations like the Red Cross, some by private charity. The remainder are provided as

uncompensated care, in the form of bad debt. Even so, the problem of catastrophic illness expense exists. The reasons for the problem are very different for the elderly than for the general population.

Unfortunately, no immediate resolution of this problem is possible without the infusion of large sums of Federal monies. Given current budget constraints this is not a feasible solution. Longer term private sector partial solutions are feasible. However, decisive action is needed now if we are to have these mechanisms in place in time to address the enormous public policy crisis that the baby boom generation will present when they become the elder boom in the ensuing decades. The catastrophic problem for the general population, in contrast, is not that people lack available insurance possibilities, but that they fail to acquire insurance protection for themselves and their families. About 30 million individuals are currently uninsured, of whom over 20 million are without coverage all year. About 10 million others (most with employment-related insurance) have insurance which is inadequate to protect them from risk of catastrophic illness expense.

The uninsured or inadequately insured are not typically out of the labor force; nor are they typically poor. Most of them work or are dependents of workers, often in small businesses. They are often part-time or part-year workers, and earn relatively low wages.

The recommendations selected for the President's consideration recognize the dangers of fiscal expansion to increase coverage of catastrophic health care expenditures. The recommendations, therefore, involve at most moderate increases in public outlays or reductions in Federal receipts. The strategy also recognizes that much of what needs to be done can most appropriately be done through encouraging development of private financing mechanisms and increasing flexibility at the State and local levels. The recommendations address three major parts of the catastrophic illness coverage problem:

- o acute care catastrophic protection for the elderly;
- o long term care protection alternatives;
- o catastrophic protection for the general population.

RECOMMENDATIONS FOR IMPROVING ACUTE CARE CATASTROPHIC EXPENSE PROTECTION FOR THE ELDERLY

The Medicare program now has coverage gaps that leave the elderly with acute care needs vulnerable to catastrophic out-of-pocket expenses. A restructured Medicare program can promote equity among beneficiaries in a way that relieves the worries of the elderly about acute care expenses, while simultaneously reducing the out-of-pocket expenses of the majority who now purchase limited insurance coverage. At the same time, we can ensure that the elderly fully pay for this increased security, rather than depending on younger generations to finance it. Restructuring is consistent with efforts to increase competition and encourage

capitated health care delivery. The recommendations presented here are also consistent with the cost-containment objectives of the President's 1988 budget.

We recommend that Medicare be restructured to provide catastrophic protection with an actuarially sound additional premium.

Medicare Part A is for inpatient and home health services and covers all Medicare-eligible persons. Medicare Part B is for physician and outpatient services; coverage depends on a premium payment which is voluntary.

The recommendation would place an annual limit on each beneficiary's out-of-pocket expenses for all Part A and Part B deductibles and coinsurance. Part A coinsurance and lifetime limits would be removed, and the maximum number of hospital deductibles would be limited to two per year. Part B cost sharing arrangements would remain unchanged. Catastrophic coverage with a $2,000 annual limit (which corresponds to an annual health care expenditure of over $10,000) would require an additional premium of $4.92 a month. That additional cost would be included in the Part B premium, which would remain voluntary. This approach would provide the elderly with a budgetable, predictable expenditure pattern for securing catastrophic acute care protection and a known out-of-pocket limit for such coverage at the beginning of each year, and would provide them with peace of mind.

This recommendation requires that the benefit be fully funded by the premium, which would be indexed annually (up or down) to insure budget neutrality. The $2000 out-of-pocket cap would also be indexed each year to account for health care inflation. Indexing assures that the tax burden of the working age population is not increased, and that those who receive the benefit pay their fair share of the cost.

Alternatively: We recommend that Medicare be restructured to provide catastrophic protection through increased cost sharing related to income.

Alternatively: We recommend that Medicare be restructured to provide catastrophic protection through increased cost sharing unrelated to income.

These alternative recommendations would finance catastrophic protection under Medicare by shifting coverage away from modest and predictable health care costs to pay for extremely high costs incurred in any year. One approach would spread the additional cost over the cost sharing contributions of all beneficiaries. The other would keep the Part B coinsurance the same for the beneficiaries whose incomes are below a certain threshold and charge higher-income beneficiaries additional copayments calculated to cover the total cost of the increased coverage.

The strength of financing catastrophic coverage by cost sharing is that it provides catastrophic coverage to all Medicare beneficiaries, not just to those who participate in Part B.

Unlike the premium approach, however, the cost sharing approach can be viewed as a tax on sickness since only those persons who use Medicare services (25% of the Medicare beneficiaries hospitalized in any given year) are made to bear the full cost of the catastrophic protection. The cost sharing burden on those who use the system, moreover, could be burdensome for significant numbers of elderly. This is the first time that cost sharing related to income has been recommended for the Medicare program. However, it is not an unprecedented change for those on Social Security, because income differentials via the tax system were introduced into the OASDI program in 1983.

RECOMMENDATIONS TO IMPROVE LONG TERM CARE PROTECTION ALTERNATIVES

Long term care is the most likely catastrophic illness risk faced by individuals and families. There are several reasons for this. Foremost among them is lack of comprehension on the part of many people about the financial risk they run in the event that they need long term care. The result is a lack of demand for long term care risk protection, and consequently only modest progress in developing alternatives for effective private sector long term care financing and service provision.

Our strategy for addressing the long term care problem is guided by four considerations. First, Americans should be encouraged to make adequate plans for their own care in old age. Second, the financing of long term care should not inhibit

maximum choice regarding the types and level of care. Third, the elderly prefer and should be able to receive the least restrictive care possible. Thus, approaches should be emphasized that allow people to remain in their own homes, or in facilities that meet multiple personal and medical needs, such as church homes and Continuing Care Retirement Communities. Fourth, the public sector is already paying half the costs of formal long term care services through Medicaid, with the remainder being paid out-of-pocket by older persons or their families. Only 1.4% of nursing home costs are paid by long term care insurance. In any given year, as many as 500,000 elderly persons may exhaust their assets and have to spend down to Medicaid while they are in nursing homes.

We recommend that the Federal government work with the private sector to educate the public about the risks, costs, and financing options available for long term care, as well as the limitations of coverage for such services under Medicare and Medigap supplemental insurance.

The elements of a campaign might include:

- Use of radio, television, and printed material targeted to both the elderly and their families, providing information regarding risks, costs, and financial protection measures.
- Continued use of currently planned official mailings to Social Security and Medicare beneficiaries to clarify current program coverage for long term care services.
- National coordination of, and assistance for, State-led efforts to assist consumers in understanding and selecting financial protection for long term care services.

- Educational and promotional efforts on private financing of long term care directed toward long term care insurers and providers.

This recommendation would have far-reaching impact on the nation's elderly and their families and their ability to plan for the needs of old age.

We recommend that the Federal government encourage personal savings for long term care through a tax-favored Individual Medical Account (IMA) combined with insurance, and amend Individual Retirement Account (IRA) provisions to permit tax-free withdrawal of funds for any long term care expense.

The first part of this recommendation uses tax-favored individual savings to encourage personal responsibility to pay for long term care expenditures. Establishing an IMA is designed to promote private financing of long term care expenses through tax-favored savings combined with long term care insurance. Individuals would be permitted to deposit a certain amount of money (e.g. $1,000 maximum) each year into a savings account restricted for use on long term care expenses. Interest accumulations would be tax free and withdrawals would not be taxed or penalized as long as their use was for nursing home care. The principal and half the interest could be used by the individual to pay for nursing home expenses incurred after age 65; if unused it would remain in the individual's estate. The remainder of the interest would purchase additional nursing home care or long term care insurance for IMA holders after the balance in their personal accounts had been exhausted.

The major strengths of this part of the recommendation are that it encourages personal responsibility for long term care needs and enhances private sector involvement in financing those needs. This strategy offers participants more months of protection than savings-only plans because of the cost sharing feature of the insurance financed by half the interest on their savings. This option is preferable to a pure long term care insurance option in that individuals would have an added incentive to participate, because if they did not require long term care services, the funds would accrue to their spouses or their estates.

The second part of the recommendation -- tax-free withdrawal of IRA funds for any long term care expense -- provides the opportunity to finance a full range of care that would allow individuals to remain in the least restrictive environment possible. A person saving $1,000 a year (indexed for inflation) from age 40 to 64 would cover 16 months of nursing home care.

The major strength of this part of the recommendation is that it builds on an existing tax-favored savings mechanism. It allows persons to save for long term care expenses, while offering substantial flexibility and choice in purchasing financial protection or services.

We recommend encouraging development of the private market for long term care insurance in three ways:

- establish a 50 percent refundable tax credit for long term care insurance premiums for persons over age 55 (up to an annual maximum of $1,000);
- provide the same favorable tax treatment for long term care insurance reserves as is now the case for life insurance;
- remove 1984 Deficit Reduction Act (DEFRA) barriers to prefunding long term care benefits provided by employers to retirees.

The major strength of this three-part recommendation is its potential for stimulating the supply of private long term care insurance options and for broadening the market for such policies -- including innovative products that combine income and health benefits for individuals in their retirement years, and individual freedom to receive the care they need in the least restrictive living environment. It is an important complement to the education campaign recommended above, which would increase awareness of the need for long term care insurance and stimulate demand for such insurance coverage.

The specific reason for establishing the refundable tax credit is to provide a direct incentive for potential buyers, (particularly lower-income families) stimulated by their increased awareness of the risks, to take action. The specific reason for the recommended treatment of reserves is that long term care insurance involves accumulation of reserves over a muc longer period than is necessary for acute health care coverage. Providing favorable tax treatment would encourage development of

more affordable long term care insurance policies. Removal of the DEFRA barriers is a prerequisite for gradual development of employment-based group coverage of long term care.

The combination of incentives will encourage the development of more flexible private insurance coverage, including home care, case-managed social and medical services under capitation, and different types of protected living environments where the elderly can receive services appropriate to their needs.

We recommend that the Federal government act to set an example for private employers and care providers. One alternative would be to offer employee-paid long term care group insurance as an option under the Federal Employees Health Benefit Program.

The Federal government is the nation's largest employer. Its leadership role would be invaluable in demonstrating the effectiveness of using large groups as a vehicle for offering long term care coverage to retirees at lower cost, at group rates, and to younger employees. Retirees might be given a choice of either paying separately for long term care insurance, or trading some of the health insurance benefits currently offered for better long term care insurance coverage. Although long term care policies are not currently available extensively to persons in their middle years, it is possible that interest in creating such policies would be generated if a large pool of individuals, such as Federal employees, were available.

RECOMMENDATIONS FOR ACUTE CARE CATASTROPHIC PROTECTION FOR THE GENERAL POPULATION

The general population includes many specific groups with differing coverage availability and coverage needs. Most of the general population are employed or dependents of an employed worker. Their protection typically comes from employment-related insurance, whether self-financed or as part of a fringe benefit package. Employers must have new incentives to expand private sector benefits to include catastrophic coverage alternatives. Historically, coverage of the poor, the near poor, and the related problem of uncompensated care have been the responsibility of State and local governments. This should continue. However, such governments need increased flexibility to develop a wider choice of alternative ways of meeting these coverage needs.

We recommend that States require all employers who offer health insurance to offer a catastrophic coverage option.

State mandates that employers who offer coverage include (but not necessarily finance) a catastrophic coverage option would allow an opportunity for the underinsured to purchase catastrophic coverage for a modest insurance premium since catastrophic coverage per se is not very expensive.

We recommend that full tax deductions be extended for health insurance to the self-employed and unincorporated businesses, as long as the coverage includes catastrophic expenses.

Until the recent tax legislation, the self-employed and owners of unincorporated businesses could not deduct the premiums for their own health business plans. The self-employed can now deduct 25 percent of their premiums. While this will help, there is little justification for not allowing certain limited portions of the employed population the same tax subsidies available to the rest of working population. The extension of the full tax subsidy should require that the self-employed and unincorporated business owners offer comparable coverage to their employees and that the coverage include catastrophic expenses.

We recommend encouraging formation of State risk pools to subsidize insurance for those whose medical condition makes it impossible or prohibitively expensive to get catastrophic insurance.

Use of an insurance pool for high risk individuals can be an effective way of reaching this small but medically and financially very vulnerable population. The subsidy should be spread over a large group -- either taxpayers or the insurer/employer community.

We recommend State innovation and initiative in such areas as loan guarantees, high-deductible catastrophic health insurance requirements for motor vehicle registrations, and greater flexibility in managing State Medicaid programs.

The catastrophic health insurance needs of persons with employment-related coverage and persons who are medically uninsurable or insurable only at very high cost have already been addressed in our recommendations. Other groups in the population can be helped substantially by the States. State and local governments must be encouraged and enabled to foster catastrophic health insurance in innovative ways which target particularly vulnerable groups in their communities.

States could, for example, institute a loan guarantee program for persons incurring high health expenses. Loan guarantees would make credit available to individuals to spread the costs of an expensive medical episode over several years. Loan guarantees, coupled with possible State subsidies to broaden the program to lower-income families, would encourage the sharing of uncompensated care costs among providers, beneficiaries, and State governments.

Another approach is for States to target specific activities or groups of people for catastrophic health insurance coverage. States could, for example, require accident-related catastrophic health insurance for all motor vehicle registrations. Driving accidents can cause disabling injuries, and many of the victims receive substantial amounts of uncompensated care from hospitals and other providers.

Increased Medicaid program flexibility will assist States in developing programs tailored to meet local needs and preferences for dealing with catastrophic expenses. States have proven their ability to meet State and local health care needs in a cost-effective manner. Among the wide range of possibilities are inclusion of catastrophic benefits as a category of service; shifting coverage toward catastrophic expenses and away from optional services; waiving income determination rules to secure family contributions toward institutional care; and other modifications to State Medicaid programs. Several alternatives are now available to State governments.

* * *

The threat of catastrophic illness is very real. Now is time, after decades of debate, to forge a partnership between government and the private sector which will help provide coverage for catastrophic illness expense.

Risk of catastrophic illness expense faces persons and families in a wide variety of economic and personal circumstances. The range of public and private coverage that currently exists is already wide. This diversity suggests the need for a variety of approaches involving every segment of employers, providers, insurers, at all levels of government; and most importantly, individuals and their families. Approaches must address the preservation of individual choice and individual responsibility at the same time that they make provision for the affordable financing of needed services.

Private sector initiative and responsible government action can lead to a strengthened health care system and the ultimate resolution of this important problem. Failure to act now will not make the problem disappear. Indeed, delay may make it harder to solve as the population ages.

CHAPTER ONE

INTRODUCTION

> **After seeing how devastating illness can destroy the financial security of a family, I am directing Secretary of Health and Human Services, Dr. Otis Bowen, to report to me by year-end with recommendations on how the private sector and Government can work together to address the problems of affordable insurance for those whose life savings would otherwise be threatened when catastrophic illness strikes.**
>
> **President Ronald Reagan**
> **State of the Union Address**
> **February 6, 1986**

With this statement, President Reagan recognized "affordable insurance for those whose life savings would otherwise be threatened when catastrophic illness strikes" as one of the major domestic issues of the 1980s. In a letter to Secretary Bowen, dated March 21, 1986, the President further explained the mandate:

> **Your efforts should include, but not be limited to, examining situations faced by Medicare beneficiaries as well as people of all age groupings, income and employment status. You should look at what the private sector and other levels of government are doing to address the problems, and examine current federal activities, from tax policy that affects private health insurance, to financing programs such as Medicare, Medicaid, and veterans' health benefits.**

Development of Report

In response, Secretary Bowen has made coverage of catastrophic illness within the overall constraints of fiscal responsibility and competing policy needs his highest priority. This report is the result of an intensive analysis effort, guided by six major values that reflect the President's belief in limited government, an unfettered private sector, and an abiding belief in the value of the family and individual freedom.

The first is family -- the belief that public policy should preserve and strengthen the family and the ability of families to take responsibility for the well-being and nurturing of all family members. The second is cost containment -- the commitment to control expenditures by fostering incentives for institutions and individuals to make the most efficient use of scarce resources. The third is competition -- the commitment to foster productivity, innovation, and growth through free, fair, and open markets. The fourth is choice -- the belief that individual freedom to make decisions and take personal responsibility for those decisions maximizes not only economic well-being but quality of life for all. The fifth is equity -- the commitment to the principle that equitable treatment of individuals, irrespective of personal or economic characteristics, is fundamental to a free and just society. The final value is Federalism -- the conviction that the States, local governments, private organizations, and individuals should have maximum authority to define the character of life in this society. The

role of the Federal government should be to foster private sector initiative and to take responsibility for those activities that cannot appropriately be carried out by other societal institutions and organizations.

To fulfill the President's mandate, the Secretary organized a team of technical experts and knowledgeable private sector representatives. The technical aspects of the study were directed by an Executive Advisory Committee (EAC). The EAC, chaired by the Secretary's Chief of Staff, was composed of the Department's Senior Management, and reported directly to the Secretary. Three Technical Work Groups, representing the most skilled and knowledgeable resources in the Department, worked under the direction of the EAC. A Private/Public Sector Advisory Committee (P/PSAC) -- composed of consumers, employers, providers, insurers, and elected officials -- also reported directly to the Secretary. In addition to their own contributions, P/PSAC members held public hearings across the country to solicit the contributions of interested citizens and private organizations. Finally, the Department entered into a cooperative agreement with Project HOPE, a private nonprofit foundation, to provide expanded access to technical expertise and logistical support for the Technical Work Groups and the P/PSAC public forums. This report represents the culmination of all these activities.

Purpose of the Report

The purpose of this report is fourfold: to highlight key issues and challenges facing Americans today in the area of catastrophic illness expenses, to document the impact of such expenses on families, to discuss emerging trends in policy thinking about coverage of catastrophic expenses, and to develop policy recommendations for consideration by the President, other government leaders, private businesses, and local communities.

The problem of catastrophic illness expenses has been identified by the President as a priority issue. But it is one among several health-related issues the President has highlighted as important to our future well-being. Others include redirecting health policy plans to emphasize maintaining health rather than treating illness, reducing the impact of medical malpractice and medical liability on health care costs, stepping up the fight against acquired immune deficiency syndrome (AIDS), and accelerating the process for bringing onto the market safe and effective new drug therapies and medical devices.

At a more general level, health is one among several social areas given priority by the President. Others include education, welfare, justice and public safety, personal freedom, and protection of the environment while making efficient use of the nation's resources.

This report is intended to help focus the public debate by providing evidence on the extent of the catastrophic illness problem and suggestions as to possible solutions.

Our hope is that the effort will help the public policymaking process decide on the fundamental question: How much do we as a people want to do about this issue at this time, given the options available and the wider context of public policy concerns and constraints?

The health care system in this country already provides substantial protection for most Americans. But for those with inadequate protection or no protection, the risk of catastrophic illness exists. If such illness strikes, its cost can be truly devastating -- destroying the hopes and carefully nurtured plans of a lifetime.

But there is no way to avoid these costs. All costs must be borne by someone -- if not by the individual, then by family members or heirs, by taxpayers of this or subsequent generations, by some providers (as charity or bad debt), or by unidentified payers (as when employers have to finance the costs of mandated coverage for employees). To the extent that these costs are not fully borne by the individual, there is the hazard of stimulating the demand for expensive health services. Developing options which moderate such demand while meeting financial needs is a major goal of this report.

With respect to catastrophic illness protection of the general population, a major concern is the cost of expanding employer-provided coverage. Since most of the general population are either in the work force or dependents of workers, these costs are important. Cost increases imposed on employers must be

financed somehow. Employers' responses will include possible wage reductions, employment reductions, or product price increases that could threaten international competitiveness.

With respect to long term care, the danger is that insurance protection, whether private or public, will lead to substitution of institutional for home care. Almost all the burden now is borne by family members and friends. Society depends heavily on these unpaid and willing human resources. Options to expand long term care financing run the risk of stimulating demand for such care in the formal market. The consequence could be enormous increases in expenditures, possibly without increasing the well-being of the elderly.

Organization of the Report

To provide a framework for the policy analysis that follows, Chapter Two describes the current health care system and the problem of catastrophic expenses. Chapter Three reviews the acute care coverage and risk patterns of the 65 and over population. Chapter Four examines the long term care needs and services of the elderly. Chapter Five reviews the acute care coverage and risk patterns of the general population. Chapter Six discusses the strengths and weaknesses of a wide range of possible policy options for improving catastrophic illness protection for the elderly with acute care needs, the elderly with long term care needs, and the general population, respectively. Chapter Seven recommends selected options for consideration by the President.

CHAPTER TWO

THE CURRENT HEALTH CARE SYSTEM AND THE PROBLEM OF CATASTROPHIC EXPENSES

The American health care system provides substantial benefits to much of the population with respect to a wide range of health-related costs. It is important to understand the system that already exists if we are to provide useful guidance as to how it can best be changed to provide better coverage for catastrophic illness.

The Current Health System

The achievements of our health care system to date are noteworthy. In this century, life expectancy has risen dramatically. There have been major reductions in infant mortality. In addition, biotechnological breakthroughs have enabled millions more Americans (through immunization, corneal and other organ transplants, and pacemaker insertion, for example) to live full and productive lives. Protection against risk of expense because of illness has also expanded with increased availability of health insurance and has become more evenly distributed among the population.

Private health benefits for workers, their dependents, and retirees from the work force have become widely available. In addition, the Medicare program for the elderly and the disabled, and the Medicaid program for many low-income persons have enhanced access to health care for the majority of people

previously underserved. With the improved availability of public and private health insurance benefits, most out-of-pocket expenses now are covered.

Along with this growth in coverage, health care spending over the last two decades has grown at a rapid rate -- a rate, indeed, that has outstripped our rate of overall economic growth. Over the period from 1965 to 1985, for example, the rate of growth of health care spending averaged 12.3 percent a year, compared to the rate of growth in our Gross National Product (GNP) averaging 9.1 percent a year. Some of this increase represented expanded services. Some represented increases in the price of the health care purchased -- due at least in part to perverse incentives built into the way payment is made for health care expenditures. Health care professionals generally made the decisions about what should be purchased; third party payers (public programs or private insurance companies) paid a large part of the costs. Thus the service provision decision was largely insulated from cost considerations.

In the decade of the 1980s, significant progress has been made by both public and private sectors in restructuring these incentives so as to increase cost-consciousness on the part of insurers, beneficiaries, and providers by linking the provision and payment decisions more directly. As a consequence, the rate of growth in health expenditures is slowing. Total spending for health care in the United States rose 8.9 percent in 1985. This is the slowest growth in 20 years, although it still reflects

some medical care price inflation. For example, 63 percent of the 1985 increase in personal health care expenditures was due to inflation (23 percent specifically to increases in medical care prices and 40 percent from general inflation), 11 percent resulted from population growth, and 26 percent from increases in the use of medical services.

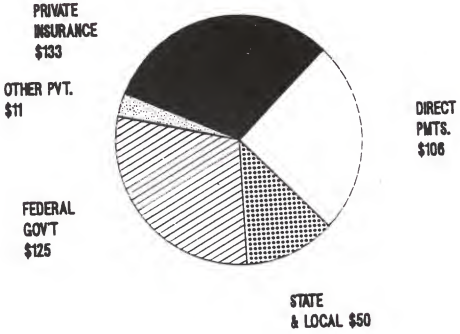
Current Financing of Health Care

Americans spent $425 billion on health-related expenditures in 1985 -- 10.7 percent of our Gross National Product, the highest proportion in our history. This is equivalent to just over $1,721 per person. Chart 2.1 shows the sources of these expenditures and the purposes for which they were spent.

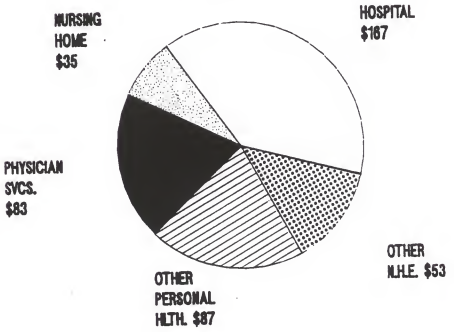
Of the total, the Federal government paid $125.4 billion (29 percent); State and local governments paid $50.4 billion (12 percent); private insurance picked up $133.3 billion (31 percent); and consumers paid the rest ($105.6 billion or 25 percent in direct payments, the remaining 3 percent in indirect payments such as premiums). Of the public expenditures, miscellaneous Federal, State, and local governments provide direct services amounting to $6.6 billion. The largest category of expenditures was for hospital stays (39 percent), followed by physician services and other personal health expenditures (20 percent each).

Chart 2.1

WHERE OUR HEALTH DOLLARS CAME FROM IN 1985 (TOTAL $425 BILLION)



WHERE OUR HEALTH DOLLARS WENT IN 1985 (TOTAL $425 BILLION)



Over the last decade, Federal sector financing has increased relative to State and local government financing, largely as a result of the rapid expansion of the Medicare program. Within the private sector, private health insurance has been increasing relative to patient out-of-pocket expenditures, principally through increased coverage of nonhospital services. The types of health care covered differ substantially across the various financing sources.

Public Expenditures

Public programs financed 41 percent of all health expenditures in 1985. Of the $175 billion in public expenditures, the highest proportion (51 percent) went for hospital services, most through the Medicare program. This represented 54 percent of the total bill for hospital care. A substantially smaller proportion (14 percent) of public expenditures went for physician services, representing 20 percent of total physician costs. A smaller proportion still (9 percent) went for nursing home care, most through the Medicaid program. This represented 47 percent of the nation's nursing home bill. Together, the Medicare and Medicaid programs accounted for almost three-quarters of the public expenditures.

Private Health Insurance

The private health insurance market includes Blue Cross and Blue Shield, commercial insurance companies, and prepaid and self-insured plans. The size of the private health insurance industry has been growing steadily throughout the last four decades, induced in part by the preferential tax treatment of employer-provided insurance. Self-insured plans -- health insurance coverage provided by employers who assume all or part of their own insurance risk -- also have been increasing in importance since the mid-seventies, due to high interest rates and legislation exempting such plans from the minimum benefit provisions of State insurance laws. Insurance companies have contributed to this growth by providing administrative and stop-loss services that facilitate implementation of, and provide protection for, self-insured plans. Of the $114 billion in private claims incurred in 1985, $59 billion went for hospital services. This represents 36 percent of total expenditures on hospital care. Private health insurance paid $37 billion on physician services. This represents 45 percent of total expenditures on physician services. Finally, private health insurance covered only a tiny proportion of the nursing home bill ($0.3 billion, or one percent of the total expenditures on nursing home care).

Out-of-Pocket Patient Payments

Of the $106 billion spent by individuals in out-of-pocket health care expenses, $22 billion went for physician services, representing 26 percent of total physician service expenditures; a total of $27 billion went for drugs and durable medical equipment, 76 percent of total purchases in these categories combined. Out-of-pocket patient expenses for hospital care amounted to $16 billion, 10 percent of total expenditures on hospital care. Out-of-pocket expenses for nursing home care amounted to $18.1 billion, 51 percent of all nursing home expenditures.

It should be noted that these estimates are underestimates of out-of-pocket costs. Payments of premiums, deductibles, and coinsurance are not fully reflected in these estimates, suggesting that the out-of-pocket expenditures may in fact account for a higher proportion of total health care expenditures.

Even these underestimates indicate that substantial amounts of health care expenditures are paid for by individuals and their families. But if these out-of-pocket expenses were allocated evenly across the population, there might be no problem. This, unfortunately, is not the case. The amounts different persons pay in out-of-pocket costs differ by orders of magnitude. The bottom 40 percent have average out-of-pocket expenses under $100 per year, while the top 10 percent have average expenditures of greater than $3,500 per year.

The major systemwide problems are (1) a bias in favor of first dollar coverage of acute care expenses (i.e., coverage of the costs everyone can expect in the course of a normal life) rather than coverage when expenses reach catastrophic proportions and (2) an almost total lack of protection in the event of long term care needs due to functional impairment.

But systemwide coverage biases do not explain the differential incidence of catastrophic illness expense. These differences also depend on the amount of insurance coverage (and whether a person is insured at all), the types of care for which a person is insured and, most important, whether in fact the person incurs extraordinary health care expenses in relation to his or her insurance coverage and income. The incidence of catastrophic expenses depends on age, income level, employment status, presence of chronic underlying illness with possibility of acute flareup, and persistence of disabling conditions.

So how much of the out-of-pocket expenses incurred constitutes catastrophic illness expenditures and for whom? This is a difficult issue. And it is not simply a measurement exercise. How one defines catastrophic expenses determines, in turn, the extent and characteristics of the policy problem and, therefore, the appropriate policy response.

The Definition of Catastrophic Illness Expenses

The most common conception of a catastrophic health event is a relatively short-term, acute, very expensive incident: a

nonfatal major automobile accident, extensive burns, liver failure necessitating a transplant, or a heart attack in which the hospital care for treatment may represent enormous expense. The general view of a catastrophic health event would also include dread diseases such as cancer or AIDS. However, neither total cost of illness nor disease-specific definitions are analytically satisfactory.

Total cost definitions ignore income differences and insurance coverage differences among persons. Disease-specific definitions ignore differences in insurance coverage and a given family's financial resources (and, therefore, their capacity to pay for out-of-pocket costs of care). Such definitions are also potentially too restrictive. On the one hand, some illnesses for some persons cumulate extraordinary expenses over time, even though the diagnosis itself would never attract sufficient attention to be selected for any list of catastrophic illnesses. On the other hand, any given list provides a definition that is unstable over time as medical breakthroughs drastically reduce the costs of some diseases, and viral mutations and environmental changes produce new dread diseases.

The most useful definition for the purpose at hand is a measure that allows us to identify illness costs which can be borne by individuals and families without having to significantly change their life style or drastically modify their expectations of living standards in the future. Such a definition allows appropriate comparisons across individuals and groups and

captures, at the same time, an intuitive sense of catastrophe. Will the financial implications of an illness, for example, use up savings that had been set aside for the children's college education? Will a catastrophic illness financially devastate the patient and family for the rest of their lives?

A simple percentage of income threshold is not satisfactory because, for extremely low-income populations, it would define as catastrophic the expense levels associated with routine and normally budgetable health care costs, including typical premium payments for comprehensive health insurance. The problem of low income is different from the problem of health care expense coverage, and is appropriately dealt with by different public policies. The most appropriate definition of catastrophic expenses, therefore, sets a dollar amount below which no expense level is considered catastrophic, however low the family's income. A percentage of income figure is then added to that amount to yield the threshold above which expenditures are considered catastrophic. Table 2.1 shows -- for two absolute dollar amounts combined with two percentage of income thresholds -- the incidence of catastrophic out-of-pocket health expenditures for the total population, for persons under 65 or in families headed by someone under age 65, and for persons aged 65 or over or in families with the head aged 65 or older.

If the definition is $2,200 plus 5 percent of income, 8.3 million persons incur catastrophic expenses in a given year.

Table 2.1

PEOPLE WITH CATASTROPHIC OUT-OF-POCKET EXPENDITURES BY DIFFERENT DEFINITIONS (millions)

Groups	Alternative Thresholds				Total Population
	$2,200 plus percent of income		$4,400 plus percent of income		
	5	10	5	10	
Total	8.3	6.4	3.8	3.3	220.7
Family Head Under Age 65	6.2	4.7	2.9	2.4	194.7
Family Head Age 65 & over	2.1	1.8	0.9	0.9	26.0

SOURCE: 1977 NMCES data aged to 1987.

Of these, 6.2 million are either under age 65 or live in families where the head is under age 65, 2.1 million are either 65 or over or live in families where the head is age 65 or over. A higher threshold and higher percentages of income yield lower incidences of catastrophic expenses. For a $4,400 threshold and 10 percent of income measure, for example, 2.4 percent of persons in nonelderly households and 0.9 percent of persons in elderly households, respectively, incur catastrophic out-of-pocket health care expenses in a given year.

Extraordinarily high levels of health care expenditure can come about for many reasons, and the reasons are typically different for the general population than for the elderly. Examples are not hard to find.

Take the case of a retired school teacher whose 70-year-old husband became ill with cancer. They had Medicare coverage. They had also bought supplemental coverage which they assumed would pay any expenses not covered by Medicare. His illness necessitated three operations, long hospital stays, numerous doctors' visits, and, finally, a nursing home stay that lasted 18 months until his death. The school teacher discovered that Medicare left substantial costs uncovered, including doctors' bills above Medicare's allowable charge and nursing home charges after 60 days. She also discovered that their supplementary policy covered little except the Medicare deductible and copayment charges for the hospital stays. They were finally

forced to sell their home and turn, practically penniless, to the Medicaid program for assistance.

Or take the case of a divorced mother of two who was self-supporting until she became chronically ill at 33 years of age. She is now 39, exists on intravenous feeding, and is hospitalized about three-quarters of every year. Her only source of income is a disability check; she is eligible for Medicare and owns a private hospital/surgical policy that costs one-third of her income from disability. For some reason she does not understand she is not eligible for her State's Medicaid program, and her health care bills far exceed her Medicare coverage and private insurance benefits. She pays what she can and is steadily increasing her debt with hospitals and physicians. Her recurring nightmare is that she will die and leave her children (aged 18 and 22) with her mountain of unpaid medical bills.

How widespread are cases like these and other instances of extraordinary suffering and financial hardship? Chapters Three and Four provide answers to this question for the elderly with respect to acute care and long term care, respectively. Chapter Five examines acute health care coverage and the incidence of expenses for the general population.

CHAPTER THREE

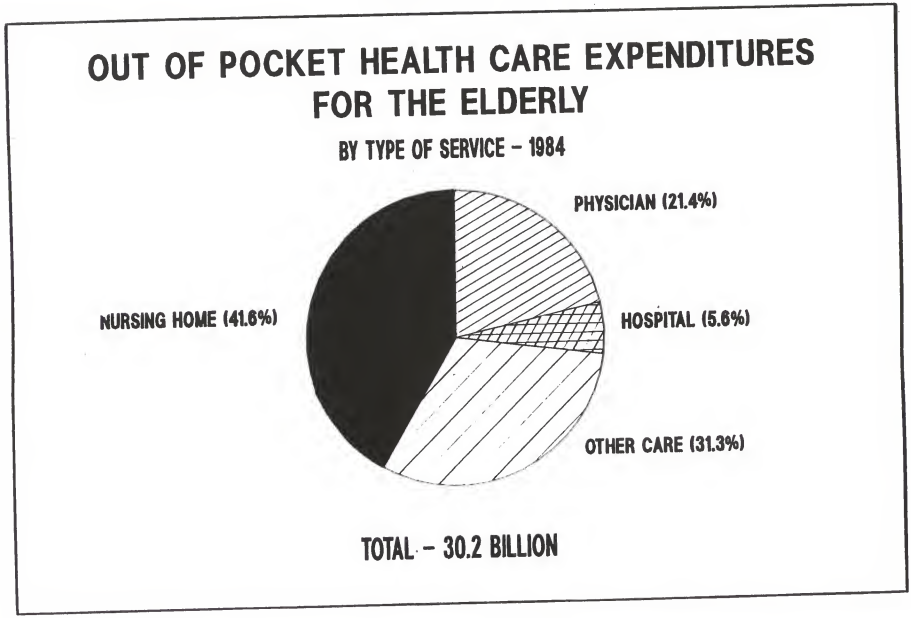
COVERAGE AND RISK PATTERNS: ACUTE CARE FOR THE ELDERLY

Elderly Americans incur substantially higher health expenditures than other age groups in the population. In 1984, for example, the average per capita expenditure on health care needs for the elderly was $4,202, compared to $1,721 for the population as a whole. Hospital care accounts for almost half (45 percent) of this. Physician services and nursing home care each accounts for about 20 percent. These estimates include expenses in connection with acute care episodes and expenses in connection with long term care (i.e., regular personal care and supervision in the form of nursing home or community-based services required in the case of long term functional impairment).

Almost all the elderly have acute care insurance protection under the Medicare program -- public health insurance provided by the Federal government to which elderly Americans are entitled by virtue of their age and their own or their spouse's contributions during their working years. Many also have supplementary private acute care coverage. In contrast to acute care, very few of the elderly have insurance coverage of long term care expenses, unless they are or become poor, in which case they are eligible for coverage under the Medicaid program.

Chart 3.1 shows the distribution of out-of-pocket health care expenditures of the elderly. As can be seen, the distribution of out-of-pocket expenditures is very different from

Chart 3.1


OUT OF POCKET HEALTH CARE EXPENDITURES
FOR THE ELDERLY
BY TYPE OF SERVICE - 1984
PHYSICIAN (21.4%)
HOSPITAL (5.6%)
OTHER CARE (31.3%)
NURSING HOME (41.6%)
TOTAL - 30.2 BILLION

that of total health care expenditures. This largely reflects lack of coverage for long term care expenses. By far the largest proportion (over 40 percent) is for nursing home care. The next highest is "other expenditures," which includes not only payments for acute care services not covered or only partly covered by insurance, but also out-of-pocket payments for long term care (other than nursing home care). This chapter addresses the issue of acute care coverage. Chapter Four examines the issue of long term care.

Acute Care Coverage Patterns of the Elderly Population

As noted, virtually all elderly Americans receive acute health insurance protection through Medicare. Many of the elderly purchase additional protection through the private insurance market, so-called Medigap policies; these policies provide valuable additional protection. Low-income elderly persons eligible for Supplemental Security Income (SSI) receive additional protection through the Medicaid program.

The Medicare Program. Medicare currently provides medical insurance for 28 million elderly beneficiaries. There are two parts to the Medicare program: Part A, which carries no premium and covers hospital and skilled nursing facility (SNF) expenses; and Part B, which requires a premium, is voluntary, and covers physician services and certain other services. The vast majority of Medicare Part A beneficiaries (greater than 95 percent) choose to buy into Part B.

Medicare Part A currently provides coverage for up to 90 days of inpatient hospital care during any one spell of illness or benefit period, plus 60 "lifetime reserve" days of hospital care. A new benefit period begins when the beneficiary has not been a hospital or SNF inpatient for 60 consecutive days. There is an absolute deductible amount applicable to the first 60-day period, after which there is a required copayment for each additional inpatient day. Medicare also provides up to 100 days of skilled nursing home care following a hospital stay. There is no deductible and no coinsurance for the first 20 days, but for the residual 80 days there is a copayment for each additional day.

Part B, after an annual deductible of $75, covers 80 percent of the cost of physician services during inpatient hospital stays up to an allowable maximum charge per visit. It provides equivalent coverage for outpatient services and covers inpatient prescription drugs. It provides no coverage for nonhospital prescription drugs, routine physician care, or "non-acute" outpatient services.

There are several aspects of the design of the Medicare program that leave beneficiaries open to risk for substantial out-of-pocket expenditures.

The first is the spell of illness concept. The benefit period under Part A is not a calendar period, as under most insurance plans -- even Medicare Part B -- but is defined by the period of illness requiring an inpatient stay. Full coverage

(after a deductible) is only provided for the first 60 days of a spell of illness. After that, a relatively high coinsurance rate (one-fourth of the hospital inpatient deductible for days 61 through 90, and one half of the inpatient deductible for all lifetime reserve days) takes effect which for long hospital stays can cumulate into enormous sums. After the lifetime reserve is exhausted, the patient is liable for the full cost.

The second design issue is the Part A deductible itself. This is set by formula, under law, each year to approximate the average Medicare payment per day of hospital care. Hospital price inflation and the reduction in average hospital stays have increased the deductible at a rapid rate in recent years. It is currently $492 (increasing to $520 in January, 1987), more than three times higher in <u>real</u> (inflation-adjusted) terms than the original level.

The third design issue is the limited nursing home coverage. Medicare covers up to 100 days of nursing home care which must be defined as required and post-hospital skilled nursing facility care. After that there is no nursing home coverage and even for that period there is a high coinsurance amount (one-eighth of the average cost of a hospital day) which takes effect after the first 20 days.

The fourth design issue is open-ended liability for unassigned claims for physician payment. Under Part B, a physician can either accept assignment, in which case he or she accepts the Medicare approved amount as payment in full, <u>or</u>

refuse to accept assignment, in which case the patient is liable (without limit) for any difference between the physician's charge and the approved amount.

The fifth design issue is that Medicare does not cover several services (e.g., outpatient prescription medicines) and provides very limited coverage of others (e.g., outpatient mental health treatment).

Finally, the Medicare benefit structure is complex enough and different enough from the insurance (typically employer-related) held by beneficiaries before they reached age 65 that beneficiaries have serious misconceptions about what is covered and not covered.

The program's structure can lead to substantial noncovered liabilities for Medicare beneficiaries' acute care expenditures, as shown in Tables 3.1 and 3.2. More than 10 percent of beneficiaries, for example, had liabilities of $1,000 or more in 1983, most commonly due to Part B coinsurance, Part B charges above the approved rate, and the Part A hospital deductible. It should be noted here that the non-Medicare-paid liabilities shown in Tables 3.1 and 3.2 are an underestimate of the acute care expenses that are not covered by Medicare. They do <u>not</u> include any expenditures for noncovered services, or SNF or in-home expenditures after the maximum coverage period.

To what extent are the liabilities left by gaps in Medicare acute coverage taken care of by the other insurance options for the elderly? We address this question in the next two subsections.

Table 3.1

DISTRIBUTION OF NET BENEFICIARY LIABILITIES
UNDER MEDICARE, 1983

Average Net Per Capita Liability	Distribution of Beneficiaries		Distribution of Net Liabilities	
	Total (Millions)	Percent	Total ($ Billion)	Percent
$0	5.3	19.6	$0.0	0.0
$1-999	19.0	70.1	4.7	45.8
$1,000-1,999	2.0	7.2	2.7	26.0
$2,000-4,999	0.7	2.7	2.1	20.2
$5,000 & over	0.1	0.4	0.8	8.0
TOTAL	27.1	100.0%	$10.3	100.0%

SOURCE: HCFA Office of the Actuary.

Note: Beneficiary liabilities are net of Medicare payments only. They are further reduced to some extent by payments under Medigap policies.

Table 3.2

SOURCES OF NET BENEFICIARY LIABILITIES UNDER MEDICARE, 1983

Average Per Capita Liability	Part A			Part B			
	Hospital Deductible	Hospital Coinsurance	SNF Coinsurance	Deductible	Coinsurance	Charges Above Approved Rate	Total
$0	—	—	—	—	—	—	100.0%
$1-999	25.5%	0.1%	0.1%	24.7%	33.0%	16.8%	100.0%
$1,000-1,999	27.3%	0.9%	0.8%	5.5%	40.7%	24.8%	100.0%
$2,000-4,999	14.6%	6.2%	5.7%	2.6%	38.5%	32.4%	100.0%
$5,000 & over	4.5%	37.9%	4.7%	1.0%	29.9%	21.9%	100.0%
TOTAL	21.7%	4.6%	1.7%	14.3%	35.5%	22.2%	100.0%

SOURCE: HCFA Office of the Actuary.

NOTE: The table represents the sources of beneficiary liabilities underlying Table 3.1. Beneficiary liabilities are net of Medicare payments only. They are further reduced to some extent by payments under Medigap policies.

Medigap Insurance. Because of the gaps in and beneficiary misperceptions about Medicare coverage, the private insurance industry has developed a set of insurance products commonly termed Medigap policies. The Medigap industry plays two important payment roles -- prepayment of normal expenses and insurance for extraordinary expenses -- and also acts as a simplifying mechanism for dealing with the complexities of the Medicare program.

Medigap policies are purchased by a majority (65 percent) of Medicare beneficiaries. Many beneficiaries hold more than one such policy. Medigap policies usually cover some or all of the Part A and B deductibles and coinsurance. A political consensus about marketing irregularities in the industry led in 1980 to the enactment of P.L. 96-265 -- known as the Baucus amendments -- which set requirements (with regard to minimum benefits and loss ratios) for policies that use the label Medicare supplement. These policies are required to cover the Part A coinsurance days and at least 90 percent of expenses for a year after Part A benefits are exhausted. The law also requires minimum coverage of $5,000 of Part B coinsurance amounts, subject to a $200 deductible. This implies that Part B expenses must be covered up to $25,000. Thus, policies that merit the Medicare supplement label provide some, though not perfect, catastrophic protection for out-of-pocket liabilities connected with Medicare-covered services.

There is considerable uncertainty about the proportion of beneficiaries who hold approved Medicare supplement policies (i.e., Medigap policies meeting P.L. 96-265 requirements). At least 30 percent of beneficiaries have Medicare supplement policies, and the proportion could be over 50 percent. Persons with group insurance coverage are more likely to have Medicare supplement policies, but an estimated 64 percent of beneficiaries with Medigap policies have individual coverage.

Because of the wide range of benefits and policies available and the lack of national level data, it is difficult to estimate the average cost of a typical policy. However, it is generally agreed that they can be expensive, despite legal restrictions on loss ratios. Information from individual states indicates a current range of $150 to $1,500 per year. Policies at the high end of this range are not affordable by many beneficiaries. Medicare supplement policies cover more than a minimum-benefit acute care catastrophic-only product and consequently cost much more. For example, a plan that provides only catastrophic benefits for acute care has been estimated to cost $160 to $170 per year.

Inadequate information about the number and types of Medigap policies in existence does not permit firm estimates of how much of the potential catastrophic burden is covered under these policies. The Congressional Budget Office -- by assuming an average set of Medigap coverage provisions and premiums and applying that to the average expenditures for those with such

policies -- suggests that Medigap policies reduce dramatically out-of-pocket expenses of those incurring high liabilities under Medicare. Of course, this method of calculation does not take account of the variation in out-of-pocket expense within the group who hold Medigap policies.

Medicaid. Medicaid is a Federal-State program for certain low-income and medically needy persons. Each State has its own program, designed under broad Federal guidelines. About 13 percent of the elderly under Medicare are covered by Medicaid. This population is often referred to as the dually entitled or crossover population.

For this population, State Medicaid programs often "buy into" (i.e., pay the premiums for) program recipients' coverage under Medicare's Part B program. Medicaid generally covers the Part A and Part B deductibles and coinsurance and nursing home care.

In several States, however, Medicaid plans have placed limits on hospital days. In such circumstances, payment for hospital services that exceed Medicaid's limits may be made by Medicare under its bad debt provisions for hospital bills or by private insurance in the relatively rare situation where the Medicaid eligible individual has such insurance. However, absent these sources, either the Medicaid enrollee may be forced to forego needed services or someone must provide treatment without compensation. In addition, although many States also provide

coverage for supplementary services such as drugs and dental care, not all do.

About 20 percent of the elderly have neither Medigap nor Medicaid coverage. This includes over two million of the poor and six million of the near-poor elderly who are not covered by Medicaid. Such persons are at full risk for the non-Medicare-covered liabilities shown in Table 3.1.

Distribution of Out-of-Pocket Expenses on Acute Care for the Elderly

Medicare covers 82 percent of the total liabilities incurred by beneficiaries for covered services (see Table 3.3). Most of the residual liability occurs for Part B. Medicare pays for more than 90 percent of expenditures on services covered under Part A, for example, versus 66 percent under Part B. This leaves residual liabilities totalling $2.9 billion under Part A and $7.4 billion under Part B. Some of these are covered by Medigap policies and Medicaid. The rest are out-of-pocket expenses paid by beneficiaries.

The pattern of medical care use does not differ much by insurance coverage. Of those with no insurance other than Medicare, for example, 79 percent have no hospital involvement in a given year. Of those with private insurance the proportion is 78 percent. The proportions are also practically the same with respect to extent of hospital use.

Table 3.3

PAYMENTS AND NET BENEFICIARY LIABILITIES
UNDER MEDICARE, 1983

	Total Expenditures	Medicare Payments		Net Beneficiary Liabilities	
	($ billion)	($ billion)	% of Total	($ billion)	% of Total
Part A	$35.3	$32.4	91.8%	$ 2.9	8.2%
Part B	$22.1	$14.7	66.5%	$ 7.4	33.5%
TOTAL	$57.4	$47.1	82.1%	$10.3	17.9%

SOURCE: HCFA Office of Research.

NOTE: This table reports Medicare payments and net beneficiary liabilities consistent with Table 3.1. Beneficiary liabilities are net of Medicare payments only. They are further reduced to some extent by payments under Medigap policies.

Out-of-pocket expense is very different for the two groups, however. For those with no private coverage, and one hospital admission of less than 61 days, the average out-of-pocket expense for Medicare covered services in a year is $878 (versus $474 for those with private insurance). For those whose time in the hospital is 61 days or longer, the average annual out-of-pocket expense for those without private insurance is $4,326 (almost three times as high as the out-of-pocket expense for those with private insurance, at $1,698). The proportions of those with out-of-pocket costs exceeding $1,500 in a given year reflect a similar disparity. For those with one hospital admission of less than 61 days, 13 percent have out-of-pocket expenses exceeding $1,500 in a year (versus 4 percent of those with private insurance). For those whose time in the hospital is 61 days or longer, 76 percent have out-of-pocket expenses exceeding $1,500 in a year, versus 35 percent for those with private insurance.

Note again, that these estimates of out-of-pocket burden are substantial underestimates because they do not include expenditures on noncovered items such as drugs; nor do they include nursing home care or in-home care after the maximum covered length of stay. Finally, as noted, since Medicare is not designed to cover long term care, these estimates do not include long term care expenditures. Such expenditures constitute the major source of out-of-pocket health expenditures by the elderly, and are addressed in Chapter Four.

CHAPTER FOUR

LONG TERM CARE FOR THE ELDERLY

The major source of catastrophic out-of-pocket expenses for the elderly, as noted in Chapter Three, is personal care and supervision on a continuing basis -- either at home or in a nursing home -- in the event of functional impairment. These expenses over an extended period can wipe out the savings of a lifetime, and very few of the elderly have financial protection for such expenses.

Long term care ranges from informal unpaid care provided by family and friends to full nursing home care. Thus, it is not typically associated with specific diagnoses, but rather with the need for assistance in activities necessary for daily living. Most persons can expect to live their life without needing long term care. However, the need for such care increases dramatically with age, and most people in need of long term care are elderly.

There is little private insurance coverage of long term care and the only public program that covers such care (except on a short-term basis following acute illness) is Medicaid -- eligibility for which is restricted to low-income or medically indigent patients. As a result, individuals wishing to plan for their long term care needs have very few options, although new systems of care are emerging.

The urgency of long term care as a policy problem is increasing as the population ages. Within the next 45 years, the

number of people over the age of 65 will more than double, and the number of people living to age 85 and beyond will almost quadruple. By the year 2030, 2.8 percent of the population will be over the age of 85 (8.6 million Americans), compared with 1.0 percent of the population in 1980.

Current Financing of Long Term Care for the Elderly

There are two major types of formal long term care: institutional care and community-based care, most of which is in-home care. Both public and private financing of long term care is heavily biased toward institutional care.

Long term care institutions include:

-- skilled nursing (SNF) facilities, equipped to provide intensive nursing services

-- intermediate care (ICF) facilities, which provide custodial and routine nursing care

-- institutions for the mentally retarded, including intermediate care facilities for the mentally retarded and private community-based residences

-- residential care facilities (e.g., board and care homes, personal care homes, domiciliary care facilities) and long-stay hospitals (including psychiatric hospitals).

Home and other community-based care is either formal care (furnished by paid providers or volunteers), or informal care, furnished free of charge by family and friends. Eight out of ten

elderly living in the community who need long term care receive all their care from family and friends. At most one out of ten receive all their care from paid providers. The remainder receive some combination of the two.

Public Funding. Public funding for institutional care, as noted, comes primarily from the Medicare and Medicaid programs, each of which has severe coverage constraints. Medicare provides some coverage of care in both nursing home and in-home settings. This is limited to a certain maximum period following an acute illness episode requiring hospitalization.

The Medicare nursing home benefit, as noted, covers only post-acute (3 days prior hospitalization required) care in SNFs. The intent is to restrict coverage to persons needing short-term skilled nursing or rehabilitative services. The Medicare SNF benefit is relatively small both as a percentage of Medicare expenditures and as a proportion of total national nursing home revenues. In 1980, the average Medicare coverage of a SNF stay was 30 days, much less than the average stay for all nursing home patients (456 days).

The Medicare home health care provisions permit payment for home-health services to those beneficiaries whose conditions are of such severity that the individuals are under the care of a physician, confined to their homes, and in need of part-time skilled nursing care, physical therapy, or speech therapy on an intermittent basis. But again, this coverage is restricted to care related to an acute illness. Passage of the Omnibus Budget

Reconciliation Act (P.L. 96-499) in 1980 expanded the home-health benefit by removing the limit on the number of covered home-health visits, eliminating the requirement for a prior hospital stay, eliminating the deductible, and allowing more proprietary home-health agencies to participate in the Medicare program.

Medicaid funds substantial amounts of long term care for the low-income elderly. About one-half of Medicaid expenditures nationwide for 1984 were for long term care, almost all of it for institutional care. Nursing home recipients who are covered by Medicaid must contribute all their income except for a small personal needs allowance ($25 per month in most States) to the cost of their care. It is estimated that approximately half of all Medicaid recipients in nursing homes were not initially poor, but "spent down" their income and resources before becoming eligible. As noted, the cost of a full year of nursing home care averages $22,000.

Private Funding. Until recently, long term care insurance was almost unheard of. Now, however, insurance initiatives in this area are beginning to appear. According to the American Health Care Association, as many as 25 insurance companies are now selling policies, with most appearing on the market within the past year. Private long term insurance is primarily for the risk of entering a nursing home, thus suffering from the same institutional bias that prevails in current public financing of long term care. Most policies have been sold on an individual basis and provide fixed payments per nursing home day which are

unrelated to the actual expenditure. Policies have a waiting period ranging from 0 to 100 days before benefits begin and a coverage period of 2 to 5 years.

The premiums for long term care are rated by age, with the rate fixed at the time of purchase in most cases. Actual premium rates vary widely, at least in part because there is such a wide range of coverage. A recent survey found that a 65-year-old purchaser could pay anywhere from $174 to $1,451 a year. For 75-year-olds the range for the same set of policies was $252 to $3,244.

Long Term Care Use Patterns

Most of the elderly, as already emphasized, do not need long term care, and most who do need such care do not need nursing home care. It is estimated that 13 percent of the elderly (3.6 million) living in the community have limitations in activities of daily living. Another 5 percent of the elderly are in nursing homes at any point in time, and the lifetime risk of entering a nursing home is about 20 percent.

Table 4.1 shows the distribution of types of long term care needs among the elderly. As can be seen, 21 percent of the elderly with long term care needs are in nursing homes. The rest are living in the community with help. Two-thirds of those in the community with long term care needs require considerable help because they are disabled in essential activities of daily living (for example, eating and moving from place to place). Of the

Table 4.1

DISTRIBUTION OF LONG TERM CARE ASSISTANCE
FOR THE ELDERLY, 1985

	Elderly Persons	
	Thousands	Percent
Nursing Home Residents	1,411	21%
Population in Community		
With IADL Impairments only	1,666	25
With ADL Disabilities	3,659	54
TOTAL	6,736	100%

SOURCE: 1977 National Nursing Home Survey, Social Security Administration Projections, and the 1982 Long Term Care Survey (adapted from Liu and Manton, 1984).

NOTE: The IADL are Instrumental Activities of Daily Living, such as shopping and cooking; ADL are Activities of Daily Living, such as eating and toileting. The ADL disabled may have IADL impairments as well.

episodes of long term care received by those living in the community, 86 percent are provided free by family and friends.

It is important to note that nursing home stays are not typically very long. Although the average length of stay in a nursing home is 456 days, this average masks important differences. Some persons enter nursing homes because they are functionally impaired and need care for that reason. But others go in order to convalesce. Still others are terminally ill when they enter. More than 50 percent of admissions, for example, are for stays of less than three months. Nearly 40 percent are for stays of less than one month. Only 18 percent of the nursing home population stays for two years or more, and for them the average stay (831 days) approaches twice the overall average.

Half of all nursing home payments are out-of-pocket expenditures by the elderly. Almost all the rest is paid by Medicaid, providing some indication of the importance of the spend-down problem. More than half of expenditures on other nonhospital, nonphysician care are out-of-pocket expenditures -- in part reflecting non-Medicare-covered acute care expenditures, but in part reflecting non-nursing-home long term care expenditures.

CHAPTER FIVE

COVERAGE AND RISK PATTERNS: THE WORKING AGE POPULATION

Most nonelderly persons in the United States (87 percent of the population) have some health insurance coverage. About three-quarters of these have private insurance, typically employment-related insurance. The remaining one-quarter have public insurance (Medicaid, Medicare for the disabled, and government insurance for members of the armed forces and their dependents). Of those with public insurance, about half have some supplementary private insurance, typically Medicare beneficiaries who have policies designed to pick up where Medicare leaves off. In addition, the Veterans Administration provides coverage for former members of the Armed Forces.

About 9.5 percent of the nonelderly population are without insurance all year. Many who cannot afford to pay have available, depending on where they live, free or subsidized care from public hospitals and public health clinics.

The Privately Insured

Nine out of ten nonelderly persons with private health insurance have group insurance that is employment-related. The remainder purchase private insurance for themselves and their dependents directly from an insurance company.

Private insurance almost always provides some type of hospital coverage. It also usually provides coverage for surgery and other inpatient physician services, use of outpatient hospital facilities, diagnostic services, and (not quite as

frequently) coverage for maternity care and physician office visits. Private insurance sometimes provides coverage for prescription drugs, for outpatient treatment of mental health care, and for skilled nursing home care. It usually does not provide coverage for custodial nursing home care, vision and hearing care, routine physicals, home health, or dental care (although dental care is being covered increasingly often).

The benefits for individuals with employment-related insurance are substantially greater than for individuals with direct coverage. The most dramatic difference involves the extent of major medical coverage; 71 percent of workers with employment-related insurance have both basic and major medical coverage, compared to 30 percent of those with other private insurance. (See Table 5.1 for 1977 data, the most recent nationally representative data available.) The lack of major medical coverage is also associated with reduced likelihood of coverage for a variety of services usually associated with major medical plans (such as physician office visits, outpatient prescriptions, or psychiatric care).

Just as employment-related insurance offers the nonelderly substantially greater benefits than other private coverage, employment-related insurance in large firms is more generous than employment-related insurance in small firms, particularly for dental care and maternity benefits. Insurance is also far more likely to be available from large than from small firms.

Table 5.1

BENEFITS OF PRIVATELY INSURED WORKERS
BY TYPE OF INSURANCE

	Employment-related insurance	Other private insurance
No. Privately insured workers	83.5 million	9.0 million
Type of coverage		
Any HMO	4.5%	1.9%
Basic only	9.1	51.7
Major medical only	15.2	13.0
Basic and major medical	70.6	29.8
Other/unknown	0.5	3.6
Breadth of coverage		
Dental care	27.9	1.5
Vision care	8.7	2.7
Outpatient prescriptions	87.8	36.0
Physician office visits	88.5	43.5
Routine physical exam	6.1	3.0
Routine physical exam	6.1	3.0
Outpatient psychiatric care	77.4	24.5
Hospital room and board		
No deductible, semiprivate	72.2	34.9
Deductible, semiprivate	5.7	5.9
Less than semiprivate	21.0	55.2
No coverage	1.1	4.0
Major medical out-of-pocket limit		
$750 or less	33.7	11.4
$751 or more	20.2	10.7
Unlimited	33.7	20.8
No major medical	12.5	57.1

SOURCE: NMCES Health Insurance Employer and Household Surveys (1977).

More than 85 percent of firms with over 500 workers provide group health insurance, compared to 65 percent of firms under 100 and 39 percent of firms under 25 employees. As these compositional differences imply -- given that most of the work force works for large firms -- most of the employed who are not insured (see further below) work for small firms.

There have been substantial changes in the type of health insurance offered since the late 1970s (as noted, the last time detailed data on insurance coverage for a representative sample of individuals was collected). The most significant changes have been the increased use of deductibles and coinsurance along with the use of stop-loss provisions i.e., a dollar maximum out-of-pocket liability. Although nationally representative data are not available, all the indicators agree that:

-- The percentage of companies using deductibles for inpatient hospital services coverage has more than doubled in the last three years.

-- Virtually all employees of medium and large businesses now have to pay some kind of deductible before their major medical coverage takes over.

-- Virtually all such employees now have some coinsurance as part of their major medical coverage.

-- Three-quarters of all such employees now have some stop-loss limit on their out-of-pocket liabilities under their major medical plan.

Expanding the use of deductibles and coinsurance have the effect of increasing out-of-pocket liability, though not typically to catastrophic levels. More frequent use of a maximum limit (cap) on the out-of-pocket liability of the insured has the opposite effect. Such limits, depending on their generosity in relation to the income of the insured, have the potential of reducing the extent of the catastrophic illness policy problem, at least for the employed members of the population.

The nature of the limits typically built into private employment-related insurance plans is, therefore, of crucial importance to any discussion of catastrophic coverage. There are no statistics on these limits for directly purchased plans or for plans offered by small businesses. The Department of Labor, however, has collected recent (1985) information of the situation for medium and large businesses. Since, as noted, these account for the majority of the private insurance coverage for the nonelderly, the Department of Labor data provide a useful indication of the stop-loss provisions of most employment-related insurance (and therefore most private insurance coverage of the nonelderly).

Somewhat over half (55 percent) of the employment-related plans of medium and large businesses had an annual limit of $6,000 or less (see Table 5.2). Almost three-quarters had a limit of $10,000 or less. About 20 percent had limits in excess of $6,000. About 25 percent had no limit at all. Coverage limits offered by large and medium businesses are more generous

Table 5.2

PERCENT DISTRIBUTION OF MAJOR MEDICAL PLANS
IN MEDIUM AND LARGE ESTABLISHMENTS,
BY ANNUAL LIMIT ON OUT-OF-POCKET LIABILITY
1985

LIMIT	PERCENT OF PLANS
$ 2,000 or less	10%
$ 2,001 -- 4,000	20
$ 4,001 -- 6,000	25
$ 6,001 -- 8,000	8
$ 8,001 -- 10,000	8
$10,001 or more	4
No Limit	25
TOTAL	100%

SOURCE: Employee Benefit Survey, U.S. Department of Labor.

than the typical directly purchased plan or the typical plan provided by a small business. With respect to lifetime coverage, most respondents to the Department of Labor Survey of medium and large firms indicated that the lifetime maximum was $250,000. A final point about employer-related insurance is possible loss of coverage when the policyholder changes jobs. Recent legislation (P.L. 99-272) has addressed this problem to some degree, by extending the opportunity to purchase coverage to former employees and their dependents for up to three years.

Public Programs

Four public programs provide health insurance to particular subgroups of the nonelderly: Medicaid for eligible low-income or medically indigent families, Medicare for eligible disabled persons and persons suffering from End Stage Renal Disease (ESRD); and programs in the Department of Defense and the Veterans Administration for military personnel, retirees, and dependents.

Medicaid covers 9 percent of the nonelderly as of 1980. However, slightly more than 40 percent of those covered are covered for only part of the year; most (two-thirds) of these have no other insurance.

Eligibility for Medicaid varies across States and is tied to eligibility for the cash welfare programs in a particular State. Anyone eligible for Aid to Families with Dependent Children (AFDC) and almost anyone eligible for Supplemental Security

Income (SSI) -- the program for low-income aged, blind, or disabled -- is eligible to receive Medicaid. In addition, people who meet all requirements for welfare other than the income level can be covered at State discretion under a State Medically Needy program. Thirty-one States have elected this option. People who do not meet the eligibility requirements for AFDC and SSI aside from income do not qualify for Medicaid no matter how poor they are or how much they spend on medical care.

Required services under Medicaid include coverage for inpatient and outpatient hospital care, outpatient testing, skilled nursing home and home health care for people over 21, and outpatient physician care including routine physicals for people under 21. Optional services, which the States can choose to offer or not, include dental, hearing, and vision. Many States, however, restrict provision of even the required services by such means as limiting the number of covered hospital days or outpatient visits. Some States also include cost sharing arrangements, usually ranging from $1.00 to $3.00 per service and rarely with a maximum out-of-pocket liability.

Medicare covers only 1.7 percent of the nonelderly population: some 3 million disabled persons and 80,000 persons with ESRD. The Medicare covered services and gaps are described in detail in Chapter Three. It is sufficient to note here that Part A (which has no premium) covers inpatient hospital care, limited care in a skilled nursing facility following hospitalization, and home health care. Part B (which has a

premium and covers only those who elect to pay it) covers inpatient and outpatient physician charges. Coverage under both parts is subject to some cost sharing and other restrictions. And there are no limits on out-of-pocket liabilities.

Military Service Related Programs constitute another important source of protection for those under age 65. In 1985, the Veterans Administration provided services to 22.4 million nonelderly retired or disabled military persons and their dependents. The Department of Defense had a population of 2.2 million active duty personnel eligible for health care at military facilities, as well as approximately 6.5 million persons eligible for services through their Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) system. CHAMPUS provides services for retirees and dependents, almost all of whom are under age 65. CHAMPUS provisions resemble those of typical employer-provided group plans in terms of service coverage, minimal cost sharing, and maximum out-of-pocket limits.

Other Public Programs include mainly State and local indigency programs and state insurance pools. Thirty-four States have some sort of medical indigency program for low-income people who do not qualify for Medicaid, frequently in conjunction with their general assistance program. A few also have risk pools for the so-called uninsurables, high-risk individuals who are unable to obtain private insurance. Such pools extend coverage to individuals who suffer from chronic diseases (such as cystic fibrosis) and are, for that reason, unable to obtain private

insurance. They are financed either by mandatory contributions from insurance companies or from State tax revenues. Finally, a few states have their own catastrophic programs. Little is known about the numbers of people covered by any of these programs or their experience with high-cost medical events.

The Uninsured: Who Are They?

According to the best information available, the number of uninsured averaged 25 to 26 million annually during the late 1970s -- practically all under 65 years of age because of the universality of Medicare coverage for the elderly (see Chapter Five). The incidence is somewhat sensitive to economic conditions, increasing during the recession of the early 1980s and decreasing since then. Although there is some dispute, estimates indicate that about 30 million individuals are currently uninsured. Of this number, about 21 million are without coverage all year.

There is substantial agreement among surveys about the characteristics of the uninsured:

-- About half are employed at least part of the year and many all year round; when their dependents are included, the employed uninsured account for about three-quarters of the uninsured population.

-- 35 to 40 percent are in families below the poverty line, and about the same proportion are in families whose income is twice the poverty line.

-- Almost 90 percent of the uninsured with jobs work for employers who do not offer insurance coverage.

Thus, the stereotype of the uninsured as someone out of the labor force and in poverty is wrong. Most of the uninsured are employed or dependents of employed people and fewer than half are technically poor. However, they frequently have lower than average incomes, are less well-educated than the rest of the population, and are employed almost always by small firms. In addition, one to two million of them are uninsured because they have uninsurable medical conditions. In other words, no one will provide them with insurance because of their current medical condition or prior history. This is not to say that the health care expenses of the uninsured are not covered. Many receive care that is financed by charity or bad debt, the combination of which may total as much as $9 billion a year.

Health Expenditure and Coverage Patterns

The distribution of total health care expenditures for the nonelderly population does not differ very much by income level, as shown in Table 5.3. Of nonelderly families, for example, 2.6 percent had expenses over $20,000 a year, 7.7 percent over $10,000 a year, and 16.8 percent over $5,000 a year. The variation in these percentages by income level is minor. In poor families, 3 percent have costs which exceed $20,000; for persons with family incomes over four times the poverty line, the

Table 5.3

ANNUAL TOTAL HEALTH CARE EXPENDITURES
BY INCOME LEVEL
(percentage of persons)

Family Income Level	Annual Expenditures			
	Over $1,500	Over $5,000	Over $10,000	Over $20,000
All Persons	38.7%	16.8%	7.7%	2.6%
Below Poverty	35.0	16.8	8.7	3.0
100-200% of Poverty	39.1	17.3	8.5	3.3
200-400% of Poverty	40.1	17.6	7.7	2.5
Over 400% of Poverty	38.1	15.6	6.8	2.2

SOURCE: 1977 NMCES data aged to 1987.

estimate is 2.2 percent. For both groups, 16.8 percent spend over $5,000 a year.

Of the persons who live in nonelderly families, estimates indicate that 77 percent have private insurance coverage all year, 8 percent have it part of the year, 5 percent are covered by Medicaid, and the rest are uninsured.

The distribution of total costs by insurance coverage is shown in Table 5.4. (This table excludes those with part-year coverage). Here the differences are striking. Those without insurance spend the least. Those with public program coverage (Medicaid) spend the most. Only 1.9 percent of those without insurance spend more than $20,000 a year, versus 2.3 percent of those with private insurance, and 7.0 percent of those on Medicaid. The distribution is similar at lower levels of expenditure. About 26 percent of the uninsured spend over $1,500, for example, versus 39.5 percent of the privately insured and 49.4 percent of those under Medicaid

The strikingly higher total expenditures of the Medicaid population reflect both the comparatively high level of Medicaid coverage and that Medicaid covers the sick and the disabled poor. Out-of-pocket expenditures by insurance coverage are shown in Table 5.5. Of those uninsured all year, for example, 4.2 percent incur out-of-pocket expenses of over $5,000, compared with 1.8 percent of those with private insurance and 1.0 percent of those on Medicaid. More than 16.6 percent of the uninsured have out-of-pocket expenses over $1,500, versus 11.3 percent of those with

Table 5.4

ANNUAL TOTAL HEALTH CARE EXPENDITURES,
BY INSURANCE COVERAGE
(percentage of persons)

	Over $1,500	Over $5,000	Over $10,000	Over $20,000
No Insurance	26.6%	9.4%	4.2%	1.9%
Private Insurance	39.5	16.7	7.4	2.3
Medicaid	49.4	29.5	17.8	7.0

SOURCE: 1977 NMCES data aged to 1987.

Table 5.5

ANNUAL OUT-OF-POCKET HEALTH EXPENDITURES,
BY INSURANCE COVERAGE
(percentage of persons)

	Over $1,500	Over $2,500	Over $5,000
Uninsured	16.6%	9.7%	4.2%
Private Insurance	11.3	5.3	1.8
Medicaid	3.0	2.1	1.0

SOURCE: 1977 NMCES data aged to 1987.

deductibles, private insurance, and only 3.0 percent of those on Medicaid.

Tables 5.4 and 5.5 highlight the situation with respect to health care expenditures for the uninsured. Together they show that those with no insurance coverage have substantially greater risk for out-of-pocket health expenditures than those with private insurance or Medicaid, even though those with insurance have much higher total health care expenditures. Out-of-pocket expenditures are lower than total expenditures even for the uninsured, however. The difference represents charity and other uncompensated care (i.e., bad debt) provided by hospitals and physicians, most of which goes to the uninsured. The costs of these types of care are spread among providers and their insurance-covered patients in the form of higher prices for care.

Uncompensated Care

Estimates cited by the American Hospital Association (AHA) indicate that $4 billion to $5 billion in 1978, $6.2 billion in 1982 and $9 billion in 1984 of charges were charity care or bad debt. (about 5% percent of operating revenues). State and local governments cover some of this uncompensated care. When their contributions are deducted from local contributions, the AHA estimates the residual uncompensated care as $5.7 billion in 1984, double what it was in 1980.

It should be noted that these amounts both overstate and understate the public policy nature of the problem. They are

overestimates because they are based on charges, not costs. Costs represent about 75 percent of charges. Some uncompensated care is paid for by State and local governments. In addition, it has been financed by private philanthropy. However, this source has been dwindling significantly in recent years. Finally, about 20 percent of it represents small unpaid bills by people with insurance. This can be regarded as a normal cost of doing business, and may be recoverable with better debt collection policies. The understatement of the problem is due to the fact that uncompensated care estimates only measure the effect of those who have gained access to the system. Those who have no public health care facility available to them when they are sick, or who do not seek needed care because they lack financial resources, have unmet health needs that are therefore uncounted in measures of uncompensated care. Research has shown that the uninsured are not only vulnerable financially, but medically as well. The uninsured systematically use less medical care than the insured population, even when they are sick, and are less likely to seek care as well.

Uncompensated care is not a new problem. But at least it has been receiving increased attention recently for three major reasons. The first is simply that the incidence of uncompensated care has increased so much in the last five years. The second is the very uneven distribution of its incidence. Public hospitals and urban teaching hospitals bear a disproportionately large part of the burden; other voluntary hospitals, including

investor-owned hospitals, bear somewhat less. The third, and most important reason, is the change in the financial environment of the health care industry. The 1980s is the era of the increasingly prudent buyer. All major purchases of health care -- including the Federal government, States and local governments, and especially the private sector -- now concentrate on paying only for what they buy, and on getting the best price for their purchases. This change has meant that items of care that used to be subsidized through higher charges on other items are being placed at risk. Uncompensated care is not the only type of care affected, but it is one of the most troubling.

Our best estimates indicate 65 to 75 percent of uncompensated care is associated with the uninsured. This means that strategies directed toward the uninsured in the general population and bad debt recovery will reduce the uncompensated care problem substantially.

States are adopting a variety of strategies to respond to the increases in uncompensated care. Some such as Florida and Michigan have expanded their Medicaid programs, introducing medically needy programs or increasing the income level used to determine eligibility. Others, such as New York and South Carolina have established revenue pools to pay for hospital uncompensated care. Finally, some States, such as Maryland and New Jersey, use their rate setting commissions to build uncompensated care into the standard rates approved by all hospitals in the State.

The Federal government is already making major contributions to the care of the indigent with the Medicaid program; the remaining Hill-Burton free service requirements; and Federal block grants for free or low cost care through community health centers, migrant health, Indian health services and the National Health Service Corps. Some hospitals with very high proportion of Medicare patients with Medicaid or high numbers of low income patients without any public support will receive a disproportionate share adjustment to their Medicare prospective payment. In addition, as noted, recent legislation requires that group rated employment-related insurance continue to be made available to laid off workers and their families and to dependents and widows of laid off workers.

Additional efforts to provide care for indigents are also appropriately the responsibility of State and local governments. OBRA and TEFRA legislation provided substantial flexibility to States concerning Medicaid. The increased possibilities of achieving greater operating efficiencies and the innovations capable of being introduced at the State and local levels as a result of more flexible Federal regulations, should be sufficient to provide for large numbers of those not currently covered by health insurance.

CHAPTER SIX

CATASTROPHIC ILLNESS COVERAGE

POLICY OPTIONS

The options that can be developed to enhance catastrophic illness insurance coverage for Americans are for all practical purposes limitless. They also span a wide spectrum in terms of their scope and the extent to which they are consistent with, or are designed to change, current health care policy initiatives and emerging trends. How are these options to be compared, and on what basis can choices among them be made?

At the most general level, the policy options described here are consistent with the concerns expressed by the President. Thus, other things equal, they promote rather than constrain the competitive forces of the market economy. They foster maximum freedom of choice at the individual level. They are consistent with the President's commitment to control the budget deficit without raising taxes. And they do not make a Federal responsibility things that are appropriately done at the State, local, or private level. Within these general objectives, options can be usefully compared along six dimensions:

The Population Covered. Options differ in the population they cover. Some, for example, are designed to cover a very narrow part of the population (for example, elderly poor persons not eligible for Medicaid). Others are designed to reach a much wider group (for example, all persons over 65 years old regardless of income or health status).

Effectiveness. Options differ also in how well they actually reach the population they are intended to cover, and how much of that population's catastrophic risk they address. An option intended to cover the uninsured population through their own purchase of insurance would not be very effective, for example, if most of the uninsured had insufficient income to be willing (or able) to avail themselves of the coverage offered.

Cost. Options differ in their total cost. Total cost here should include not only the total direct costs -- public (Federal, State, and local) and private (out-of-pocket) -- but also additional expenditures due to increased health care utilization stimulated by the policy change.

Efficiency. Options differ in the extent to which they cover the population they intend to cover without opening up participation to a much wider group. An option designed to reach those who were employed but without insurance, for example, would not be very efficient if its design enabled those who already had employer-provided insurance to transfer over to the new program.

Indirect Effects on Other Markets. Options differ in what might be called their secondary effects. A policy that requires employers to provide a certain amount or type of coverage, for example, presents employers with the problem of financing the additional fringe benefits. To do so, employers may reduce their work force, lower wages, or raise product prices -- with potential effects on competitiveness, even at the international level.

Feasibility. Options differ in their administrative and political feasibility. An option which is readily understandable by beneficiaries could contribute to administrative feasibility. An option that can be implemented by regulatory change under existing legislation often will be more feasible politically than one that requires new legislation.

Although there are numerous possible options, they fall into four major categories. The next section of this chapter provides a brief description of each, along with an overview of their advantages and disadvantages in terms of the general policy objectives and program dimensions identified above. The rest of this chapter then describes and assesses options for expanding catastrophic illness coverage for the elderly, long term care, and the general population, respectively. Chapter Seven recommends a preferred subset of the options described below.

Types of Options

Policy options for expanding catastrophic illness expense coverage fall into major categories according to the method by which they expand coverage:

(1) Program Restructuring. Program restructuring alters coverage directly by changing the eligibility and payment rules of government health care financing programs. The two major public programs are Medicare for the elderly and Medicaid for the poor and medically needy. The main advantage of Medicare program restructuring is that it directly achieves the desired coverage

changes. In addition, since beneficiaries are already familiar with the program, restructuring is often a more understandable and more welcome method of extending coverage than new policy initiatives. Existing programs have already developed administrative mechanisms, so the additional overhead costs for catastrophic protection can be minimal. With adequate premium or coinsurance increases, program restructuring can also be done within the existing budget.

The major disadvantage of a restructuring approach is that a poor design may inappropriately increase the role of the Federal government where private mechanisms may be more appropriate. One powerful restructuring option that is considered below involves relating the structure of Medicare benefits to beneficiary incomes. With regard to the Medicaid program, some proposals would increase State financial responsibility and run the risk of being politically unpopular.

(2) Incentives to Purchase Catastrophic Insurance. Such incentives can be provided to employers or individuals through direct subsidies, tax deductions, or tax credits for purchase of insurance. They can be provided by the Federal or State governments. The main general advantages of using incentives to expand coverage are that they work through the existing market for insurance; they also provide the individual with the choice of whether to purchase insurance and, if so, a choice among the insurance plans meeting the specified catastrophic coverage requirements. The effectiveness in stimulating the purchase of

catastrophic insurance is directly related to the generosity of the subsidy or tax break.

The main general disadvantage is the direct expenditure or the lost tax revenue. Additional disadvantages are that incentives to employers will only reach those uninsured who are employed and that tax deductions for individuals will not reach those persons too poor to be a part of the income tax structure. Note also that recent changes in tax laws may have reduced the feasibility of options that depend on tax credits or deductions.

(3) Saving. Such a strategy either provides incentives for increased savings or makes substantial amounts of cash directly available from private resources. The most obvious option is an Individual Medical Account (IMA) which provides a tax credit to accumulate savings whose use is restricted to medical insurance purchase or expenses. Another option is a loan guarantee against assets (such as a home) to enable persons to borrow for medical expenses.

The main general advantages are that this type of option works through existing markets and preserves individual freedom to decide which are the most needed expenditures. The major disadvantage is that these saving options depend on the willingness (or ability) to save, or the existence of individual asset levels high enough to be attractive to banks. They will therefore, not be very effective at expanding coverage for most of the uninsured, who are members of lower income families.

(4) Regulatory Strategies. Regulatory strategies expand catastrophic coverage by mandating institutions (employers, insurance companies, providers) to provide coverage to the eligible population or by requiring individuals themselves to acquire coverage. The main advantage of regulatory approaches is that their effectiveness is likely to be high to the extent that coverage becomes a legal obligation. Regulatory options rely on the private sector to provide catastrophic protection. The main disadvantage is that they can interfere with the normal functioning of markets. Options that require employer payments result in distortions not only in the markets for health insurance and health services but in labor and product markets as well, as employers react to the expenditures imposed on them. But options that require availability of coverage without mandatory employer payment may lead to increased insurance premiums, which could diminish their effectiveness.

SPECIFIC OPTIONS FOR CATASTROPHIC COVERAGE OF ACUTE CARE EXPENSES OF THE ELDERLY

Program Restructuring

Option: Restructure Medicare to provide catastrophic protection with an actuarially sound additional premium.

This option represents the most direct approach to providing additional catastrophic protection. It would remove all Part A coinsurance and lifetime limits and place a limit on combined Part A and Part B liabilities. For example, catastrophic

coverage with a $2,000 annual limit on each beneficiary's out-of-pocket expenses (which corresponds to an annual total health care expenditure of over $10,000) would require an additional annual premium of $59. This would cover a maximum of two $520 hospital deductibles per year. The additional cost would be included in the Part B premium, which would remain voluntary. Such a premium approach to restructuring is direct, simple, and affordable for nearly all beneficiaries. The catastrophic risk would be shared by all Medicare beneficiaries under this option, not only the ill as under other approaches.

Both premiums and annual cost limits would be indexed to reflect changes in the costs of providing catastrophic coverage, in order to avoid budget expansion. The low premiums reflect the fact that the new coverage would utilize existing administrative mechanisms, and not require an increase in either the overhead costs for the Medicare program or the size of the Federal bureaucracy. This approach also reflects a simplification in the structure of Medicare from the viewpoint of both beneficiaries and the providers of health care. Although most of the 32 million beneficiaries would participate in the program, a few might not be covered if the cost of the additional Part B premium led them to drop Part B, a most unlikely event.

One possible disadvantage of this option is its potential for reducing the scope of an existing private market, providing public insurance in an area where private insurance had previously existed. A requirement of this approach is that the

premiums and the out-of-pocket limit need to be indexed annually to reflect increased costs of catastrophic coverage. Otherwise, government costs will increase.

> Option: Restructure Medicare to provide catastrophic protection with a reduction in first dollar coverage (i.e., increasing deductibles and/or imposing front-end coinsurance), with or without relating deductibles and coinsurance rates to income.

This option provides an alternative method of financing catastrophic protection under Medicare, by shifting coverage away from initial health care costs to pay for costs over an extremely high annual limit. There are numerous ways to implement this restructuring. For example, catastrophic coverage with a $2,000 annual limit on each beneficiary's out-of-pocket expenses and limiting the $520 Part A hospital deductible to no more than twice per year would require the following new coinsurance: inpatient hospital coinsurance of $10 per day for days 2 through 11; skilled nursing facility (SNF) coinsurance of 10 percent of the average daily cost of care, for up to 100 days of care; home health coinsurance of 10 percent of the average visit cost, for up to 100 visits; and an increase in the Part B deductible from $75 to $170. If the strategy of relating cost sharing to beneficiary income is chosen, the additional cost sharing required to cover the catastrophic coverage could be spread over higher income beneficiaries only (for example those whose incomes are high enough for their Social Security benefits to be taxed).

This approach provides catastrophic coverage for all Medicare beneficiaries, and it preserves the amount of Medicare

costs that are, at higher cost, currently privately insurable. This approach increases the elderly's total out-of-pocket costs for securing catastrophic coverage. The recommended cost sharing restructuring is similar to the usual provisions of private health insurance. In order to prevent budget increases as program costs rise, all coinsurance levels must be indexed. The major criticism of this method is the inequity of financing the benefit by charging the users of services rather than spreading the cost among all Medicare beneficiaries.

Option: Require prepaid risk-based insurance plans under Medicare to offer catastrophic coverage.

This option builds upon other administration initiatives to encourage capitated health care delivery in a competitive market place. Medicare currently allows beneficiaries to enroll voluntarily in prepaid risk-based plans under TEFRA. In many instances the plans currently offer (with or without a supplementary payment) catastrophic benefits beyond those provided under Medicare. In addition, voucher legislation has been proposed to expand substantially the types of prepaid plans and the range of benefit packages that qualify. Voucher legislation has provoked virtually no Congressional interest. Like the TEFRA-covered plans, these plans would accept a fixed payment from Medicare in the form of a voucher.

The voucher proposal would open up for the over-65 population a range of insurance options similar to what currently exists for those under 65. It is unclear what proportion of the

Medicare eligibles without Medigap would choose the voucher alternative, making it unclear also how much catastrophic coverage would be expanded for those who currently lack it.

Incentives to Purchase Insurance

> Option: Subsidize purchase of Medicare supplement policies by low-income individuals either through a voucher or refundable tax credit.

This option could be effective in reaching many who do not now have supplementary catastrophic insurance -- how effectively would depend on the generosity of the subsidy. There is, however, great uncertainty about how high the subsidy level would have to be to achieve its purpose. The option would tackle the risk for catastrophic expenses that Medicare supplement policies do not typically cover. It would be somewhat inefficient, since it would substitute for private coverage currently held by many low-income people. For example, about 50 percent of those with incomes between $5,000 and $7,000 now hold Medigap policies, and many of them would be eligible for the subsidy. A straight tax credit rather than a refundable credit would be less costly, but would also be less effective because it would reach fewer people. This option is administratively complex.

> Option: Provide incentives for either sellers to offer or buyers to purchase catastrophic-only Medigap policies, either by subsidies or tax penalties.

This option is designed to address the problem that few catastrophic-only policies are available in the current market. The premiums for policies that include catastrophic coverage are thus high because the catastrophic benefits are tied to other benefits.

One subsidy alternative is to exempt insurance company reserves for these types of policies from Federal taxes. Another would be to amend the Deficit Reduction Act of 1984 (DEFRA) so as not to tax employer insurance reserves for retired workers with policies that meet catastrophic requirements. An alternative would be to exclude first-dollar coverage from the allowable deduction. This approach would discourage first-dollar coverage, a feature which stimulates higher utilization, which in turn increases Medicare expenditures. It may also make catastrophic insurance premiums more affordable. This option would probably be somewhat effective in expanding the amount of catastrophic-only insurance available. It would probably add little additional coverage for the population not now covered by Medigap of any kind. Most of these are low-income persons who choose not to spend their incomes on insurance protection. It is not at all clear that they will place catastrophic-only insurance much higher than current insurance alternatives on their list of spending priorities.

Option: Implement a tax-favored Individual Medical Account (IMA) for savings used to buy basic post-retirement health insurance.

This plan addresses the catastrophic acute care issue through a restructuring of Medicare. It is designed also to address the long run issues of Medicare Trust Fund solvency and cost containment. In order to receive the tax subsidy, individuals would have to accept a higher annual Medicare deductible, based actuarially on the amount saved when they become eligible for Medicare. A refundable tax credit rather than an income tax deduction for IMA savings would enhance the appeal of this plan to lower-middle income families. The option represents a relatively sweeping reform phased in over several decades. There are many uncertainties associated with such a proposal, including how many persons would contribute, how much it would cost in foregone revenue, what sort of effective catastrophic protection it would offer, and whether persons would be willing to accept subsidies now for future flexibility.

Regulatory Strategies

Option: Modify Medigap insurance regulations to improve the catastrophic protection available.

Some changes to P.L. 96-265 would do much to improve the catastrophic protection of the 65 percent of Medicare beneficiaries who purchase Medigap policies. The principal change would be to cover fully Part B coinsurance above some

limits. In addition, exemptions from P.L. 96-265 for certain types of plans (e.g., HMOs) could be removed.

Such changes would improve the catastrophic coverage of those who purchase Medigap insurance. They would not address the problem of coverage for those who do not buy Medicare supplements. Since insurance regulation is a State responsibility, an alternative approach is for individual States to toughen Medigap insurance standards. States could, for example, require that insurers offer a low-cost catastrophic-only policy and that more expensive Medigap policies that provide first-dollar coverage also provide catastrophic protection. The Medigap industry's response to such a requirement is open to speculation.

Option: Encourage formation of State risk pools.

Several States have enacted laws establishing comprehensive health insurance associations, or "risk pools", which offer affordable health insurance to persons who are otherwise unable to purchase it and who might become medically indigent if they become seriously ill. Most of these currently have lifetime benefit limits and thus provide limited catastrophic protection.

State risk pools with specified minimum benefit packages would expand coverage to those elderly who cannot now obtain Medigap coverage at affordable prices. They would do nothing directly for those whose low incomes render even "affordable" plans an expensive luxury. Some costs that are now paid by

Medicaid or absorbed as charity care by hospitals would be shifted to the risk pool.

The financing of such pools is an important issue. They could be subsidized either by State tax revenues or by a charge on health insurers. The latter alternative provides a break for self-insurers at the expense of insurance companies. It must also be recognized that State risk pools, by improving access to care, may increase the total cost of care by increasing utilization.

SPECIFIC OPTIONS FOR COVERAGE OF CATASTROPHIC LONG TERM CARE EXPENSES

Incentives to Purchase Insurance

> Option: Provide tax deductions or credits to individuals purchasing long term care insurance policies.

Providing favorable tax treatment to persons buying long term care insurance would stimulate the private market. One approach would provide a 50 percent refundable tax credit, up to a maximum of $100, to persons over age 55 purchasing long term care insurance. A refundable credit would encourage low and middle-income persons to consider purchasing insurance, and the $100 maximum would limit the amount of the subsidy to wealthy persons. A $100 tax credit represents a subsidy of 10 to 25 percent of the cost of currently available policies. The cost of this credit would be modest initially, since only 200,000 people now have long term care insurance. The impact of this approach

would be uneven because of wide variations in the premiums and types of policies being offered.

Option: Restore employer tax incentives to provide employment-related long term care insurance.

This option encourages development of group long term care insurance, which could substantially increase its affordability and attractiveness. A major deterrent to development of this market is the restriction on prefunding long term care benefits imposed by the Deficit Reduction Act of 1984 (DEFRA). As a result of DEFRA, investment earnings on retirement health plan assets are subject to current income taxation. In addition, employers are prohibited from assuming increases in medical costs (on which long term care cost estimates are usually based) in determining the amount that can be put into the fund tax free. One proposal would restore these two pre-DEFRA tax advantages, but only for prefunding retiree benefits for long term care not for all retiree health benefits. The cost of these tax changes would be minimal in the near term because employers do not now offer long term care insurance. Even with the option, development of the private market will be difficult and could take many years.

Option: Lift the tax on interest on reserves for long term care insurance.

Long term care insurance, much like whole life insurance, involves the accumulation of reserves over decades. Unlike life

insurance, the interest on those reserves is taxed at the corporate rate -- now 34 percent under the recently passed tax reform legislation. This option would provide favorable tax treatment comparable to that for life insurance reserves. If the tax on reserves were eliminated and the savings were passed along to the consumer, premiums for insurance purchased at age 65 could be reduced by about 11 percent. Savings would be even greater for insurance purchased at younger ages because interest on those reserves would be compounded over a longer period of time. Premiums on policies purchased at age 55, for example, could be reduced by as much as a third. The initial cost of this option would be small because of the small number of long term care policies now being sold. If the market expands significantly in the future, the cost of foregone tax revenues would rise accordingly.

Option: Implement a tax-favored savings account or IMA combined with insurance, to be used for nursing home expenses.

This option encourages individuals to save for future long term care needs through tax-favored savings. IMA deposits might be excused from tax (as with an IRA) or qualify the depositor for a limited tax credit. Interest accumulations would be tax free, and withdrawals would not be taxed or penalized as long as their use was for nursing home care. Fifty percent of the interest on the account would be used to fund a risk pool that would cover expenses incurred for nursing home care after the balance in the

account had been exhausted. The maximum the depositor could withdraw or pass on to heirs would be the principal plus 50 percent of the interest. Individuals who deposit less than the maximum amount would have nursing home benefits of shorter duration.

A person saving $1,000 a year (indexed for inflation) from age 40 until age 64 would be entitled to nursing home care at a rate of $50 a day (again indexed for inflation) for 25 months. Multiple nursing home stays up to 25 months duration would be covered. This amount would cover 82 percent of current nursing home stays.

The major strengths of this option are that it encourages personal responsibility for long term care needs, and it enhances private sector involvement in financing those needs. In contrast with plans that involve savings without insurance, this proposal offers participants more months of protection because of the cost sharing feature of risk pools. Unlike a pure insurance approach, IMA account holders who do not have to use their investment for nursing home care will have some of their investment to leave to their heirs. Unlike pure long term care insurance, therefore, a strong incentive exists since something is returned to the investor if long term care services are not used. It is unclear how much additional savings would be generated by this option, however. The attractiveness to low-income families would not be great, although middle-income families may find the tax advantages and insurance protection

appealing. Finally, this plan would not provide any additional incentive for the use of home care rather than nursing home care. To the extent persons opted for this plan, total Medicaid expenditures would be reduced in the longer run, since Medicaid finances approximately half the nursing home care in the United States.

> Option: Implement an IRA from which tax free withdrawals can be made for any long term care expenditure.

Like the previous option, this option also encourages private saving for long term care needs. By allowing tax-free withdrawal of IRA funds for any long term care service, this proposal allows individuals to finance a full range of care that would allow them to remain in the least restrictive environment possible. Unless participants purchased long term care insurance, however, their savings would be able to pay for a shorter period of care than the previous option. A person saving $1,000 a year (indexed for inflation) from age 40 to age 64 would only cover 16 months of nursing home care, rather than 25 months as above. This option would also be unattractive to low-income families. Finally, Congress may be unwilling to reopen the IRA debate.

> Option: Promote State Home Equity Conversion (HEC) programs.

This option is intended to tap some of the $700 billion of home equity held by elderly Americans to provide additional

liquidity for house-rich/cash-poor persons to pay for long term care without being forced to sell their house. HEC programs offer to buy homes for the elderly in return for a regular payment stream equal to the purchase price of the house, plus interest, amortized over the expected life of the seller. Most current plans guarantee that the seller is never displaced from his or her home. A major problem with this option is that neither elderly persons nor financial institutions are making much use the HECs already available in some States. The elderly show reluctance to mortgage the only asset many of them have to leave to their heirs and some fear that without ownership of their home they may be forced out of it. Financial institutions are wary of the potential public relations problem of having to foreclose on elderly persons who are still in their homes when the payment stream has come to an end.

Other Approaches

> Option: Facilitate development of long term care under capitated mechanisms as a way to spread risk.

Capitated delivery systems such as HMOs have grown in importance in recent years because of their ability to provide appropriate levels of service while controlling escalating health care costs.

The intent of this option would be to use a direct subsidy, tax break, or technical assistance to stimulate development and growth of these alternative service delivery mechanisms. In

addition, it is important that they not be made subject to regulations that do not apply to more traditional forms of insurance. Less than one million Medicare beneficiaries are currently enrolled in capitated health care delivery systems. Thus, the initial impact would be minimal.

> Option: Offer information and/or technical assistance to business and insurance companies to stimulate further development of innovative insurance strategies for long term care coverage.

In the past few years, increasing recognition of the need for protection in the event of impaired function in old age is stimulating innovative insurance strategies on the part of business and insurance companies. Disseminating information about these strategies and technical assistance to implement and further refine them has the potential of expanding the private market in long term care insurance.

Two examples are deferred disability plans and annuities explicitly designed for use in the event of long term care expenditure needs. These can be designed as part of a fringe benefit package or purchased by individuals. A deferred disability plan uses the assets accrued from life insurance policies and pension plans as a funding source for long term ca (a way for the insured to use these benefits, if in need, rathe than bequeathing them for use by their heirs). The annuity ide is essentially a form of insurance under which the individual pays a premium in return for a stream of benefits payable upon

occurrence of a specified event (for example, being diagnosed as needing personal care and/or durable medical equipment on a continuing basis for help in activities of daily living).

Option: Provide tax deductibility for respite care.

In some, perhaps many, families the burden of care becomes too great, not because of the nature of the care itself, or because it is given unwillingly, but rather because the burden is unremitting. Often there is no one and no service to provide the caregiver with time off -- to go shopping for an afternoon once a week or take a vacation with other family members.

This option would at least marginally help a family member to continue giving care. In addition, informal caregiving often provides the benefits of case management; close relatives are in an excellent position to know what is needed and to make the best decisions about meeting competing needs. The main argument against it is that it would be inefficient. In most cases the tax deduction or refundable credit would go to persons who would have continued the caregiving without it.

Option: Offer employee-paid long term care group insurance as an option under the Federal Employees Health Benefit Program.

The Federal government is the nation's largest employer and in its leadership role could usefully demonstrate the effectiveness of using large groups as a vehicle for offering long term care coverage to retirees at lower cost, at group

rates, and to younger employees. The Office of Personnel Management has expressed an interest in exploring opportunities to establish such an option for federal employees.

Retirees might be given a choice of paying separately for long term care insurance or of trading some of the health insurance benefits currently offered for better long term care insurance coverage, with no change in aggregate government contributions to the benefit plan. Although long term care policies are not currently available to persons in their forties and fifties, it is possible that interest in creating such products would be generated if a large pool of individuals were available.

Option: Mount an intensive information campaign in nontechnical language to improve public understanding of Medicare and Medigap coverage limitations.

A major problem in the long term care area is that consumers are typically unaware of the coverage limitations of Medicare and Medigap policies and about the risk they face for long term care needs.

When the American Association of Retired Persons (AARP), for example, asked members about the need for, and cost of, long term care services, one-third had no idea what the cost of long term care services would be for the average person. Furthermore, when asked if they thought Medicare would finance any long term care services they might need, four out of five said yes. When asked if Medicare supplemental insurance policies would also meet the

costs of long term care service, half the respondents thought that they would. Whatever else government does in the long term care area, it must inform the public adequately and in plain English that Medicare does not cover long term care and that most Medigap policies address gaps in acute care coverage, not long term care needs. Corrective actions are currently underway within the Department of Health and Human Services. The impact it will have in stimulating a broader long term care insurance market is difficult to estimate.

Option: Encourage development of innovative technologies and approaches to the delivery of long term care.

It is important to encourage development of innovative technologies and approaches to the delivery of long term care, so that people needing care can live in the least restrictive settings possible. Private retirement homes, many affiliated with religious organizations, provide an intermediate level of care between at-home services and nursing homes. Continuing care retirement communities are developing to meet multiple needs, including housing, health, and social services. Methods of providing long term care service with comprehensive case management can redress the imbalance of current financing mechanisms favoring costly institutional arrangements. These and other approaches being developed in the private sector hold promise for the future.

SPECIFIC OPTIONS FOR CATASTROPHIC COVERAGE OF THE GENERAL POPULATION

Program Restructuring

Option: Amend the Medicaid statute to limit out-of-pocket cost sharing and broaden limits on covered services for Medicaid-eligible beneficiaries.

This option would provide full protection for current beneficiaries. It would not address the problem of uncovered low-income persons. Since most Medicaid beneficiaries in States that limit coverage are permitted longer stays by the hospitals if medically necessary, the primary beneficiaries of this option would be hospitals which currently absorb as "charity care" hospital stays beyond the Medicaid limit. To the extent that this requirement limits the number of hospitals able or willing to accept Medicaid patients, the option should increase access for current Medicaid beneficiaries. But since there is little evidence that Medicaid beneficiaries pay for services beyond the limits set by the State out of their own pockets, the reduction in catastrophic out-of-pocket expenditures actually experienced would be very small. This option would increase Federal and State outlays. One way to limit these increases is to set a high limit (perhaps several thousand dollars per year) above which acute care expenses would be fully covered. The option is not expected to stimulate much additional utilization.

Option: Amend the Medicaid statute to mandate that all States implement medically

needy programs with uniform eligibility requirements.

Currently, thirty States provide Medicaid eligibility to low-income persons with catastrophic illness expenses. This proposal would make that coverage universal, while maintaining the concept of Federal/State shared responsibility and the right of the States to set the income eligibility level for cash assistance, which is the initial basis for determining Medicaid eligibility. It would increase Federal and State budget outlays. It could also be inefficient to the extent that it substituted for the employment-related insurance that some of this income group currently have.

Option: Permit all individuals below some income level to purchase Medicaid coverage on a sliding premium scale depending on income.

This option is directed toward the poor and near-poor who do not currently have access to public program coverage. In addition to stimulating purchase by those currently uncovered, this option would also enable Medicaid recipients whose incomes are above the AFDC eligibility level to retain their Medicaid coverage (which is not now the case). The lower the share the recipient pays, the more likely the person is to participate. However, the larger the subsidy the more the option would substitute for employment-related group insurance.

A plan which included all people below 125 percent of the poverty line with premiums limited to 5 percent of income could cost as much as $15 billion if all eligible people enrolled. A

program which had beneficiaries paying a larger share of the premium and targeting a narrower group around current Medicaid eligibility levels would cost much less. Because Medicaid covers much more than catastrophic care, this type of Medicaid buy-in is not efficient as a means of providing catastrophic coverage. It does, however, cover the health care needs of a group currently excluded from coverage.

Incentives to Purchase Insurance

> Option: Allow the self-employed and unincorporated businesses to take full tax deductions for health premiums as long as they extend the same coverage to all their employees and offer a catastrophic coverage plan.

In the recently enacted tax reform legislation, preferential tax treatment of health insurance costs was extended to self-employed persons, who may now deduct from their taxable incomes 25 percent of health insurance premiums. This option would increase the deductibility to 100 percent and cover all self-employed persons and unincorporated businesses on the condition that catastrophic coverage is included in health plans offered to all employees. This would provide more equitable tax treatment for all employed persons, and would encourage health insurance coverage in many firms that do not now offer group insurance.

This option would increase the revenue loss associated with the current tax treatment of health insurance. However, it would not include any hidden costs to employers. Also, it has a good

chance of being effective in reaching many of those at risk. We do not know how many workers who work for unincorporated businesses are not offered health insurance coverage, but their coverage is likely to be low.

Option: Limit tax deductibility to employers who provide catastrophic coverage.

This option would provide a strong incentive for employers who do not now include catastrophic coverage in the plans they offer. It would reach the estimated 7.4 million workers and dependents with employment-related insurance who are underinsured. But it would not reach the employed who do not now have employment-related insurance, nor the unemployed. The revenue loss of this option would be minimal.

Option: Provide technical assistance to facilitate provision of insurance by small firms.

It is possible that small employers are not fully informed about the availability of small group insurance. Complete and accessible information could be provided. In addition, technical assistance could be provided to facilitate the formation of groups of small employers to encourage risk pooling and, thereby, spread the risk of catastrophic expenses (a relatively rare event) over a large number of firms. To promote the availability of catastrophic-only coverage (and therefore more moderately priced plans), there also could be an exemption from State minimum benefit laws, which now frequently require first-dollar

coverage. First-dollar coverage is relatively expensive and provides a further disincentive for small employers.

It is unclear how effective technical assistance would be in stimulating coverage of the currently uncovered employed. Since insurance regulation is the province of the States, changes in minimum benefit laws would require 50 separate legislative actions. States are becoming increasingly aware of the catastrophic coverage problem, however, so such legislation might be forthcoming in many instances.

> Option: Encourage formation of State risk pools to subsidize insurance for those whose medical condition makes it impossible or prohibitively expensive to obtain insurance.

The primary function of a risk pool is to provide health insurance to people who are unable to obtain it because of pre-existing conditions. An effective risk pool should also make it much more attractive for small firms to provide insurance for their employees by providing a safety valve in the event of having more than an actuarially "fair share" of employees who are at the extreme high end of the expenditure range. Large employers, simply because of their size, run a lower risk of unacceptably high costs because of such persons.

The major issues with respect to risk pools are how high the subsidy should be set and who should pay it. If the subsidy is too low, it will not lower the premium cost sufficiently for many of these persons to purchase coverage. If it is too high, it runs the risk of undercutting the private market for small group

insurance by attracting people who previously had been buying insurance in the general market. This problem could be eliminated by screening applicants for medical conditions. The subsidy should spread over some large group -- either taxpayers or the insurer/employer community. However, it is important that it not be underwritten just by insurance companies. Many large companies self-insure, and restricting risk pool responsibility to formal insurance companies is an implicit subsidy to those employers who provide their own coverage.

Option: Subsidize the purchase of insurance by or for low-income persons.

This option would be effective for the poor members of the uncovered population, many of whom are not employed for even part of the year. It could take the form of a direct cash payment for purchase of insurance or a refundable tax credit. (A simple tax credit would not reach the majority of the low-income, who are too poor to pay taxes.) The public cost of such a subsidy would be substantial, however. It would also be inefficient to the extent that it included workers who already had employment-related insurance. More than two-thirds of low-income workers now have private insurance, as do more than half the workers whose incomes are actually below the poverty line. The subsidy could displace the cost now borne by the fringe benefits of those workers.

Saving

Option: Stimulate savings for extraordinary medical need through a tax-favored Individual Medical Account (IMA).

This option encourages individual responsibility to save for one's future needs. Any additional savings generated by this mechanism would also contribute to overall economic growth. A disadvantage is that it would involve tax expenditures. In addition, it would not be effective in covering most of those without insurance because these individuals typically have low incomes and do not have substantial savings out of those incomes. Finally, the IMA approach does not involve the concept of spreading risk, making it an inefficient form of protection for an unlikely event.

Option: Provide State guaranteed loans to cover extraordinary medical expenses for individuals unable to obtain loans in the private market.

State loan guarantees would make credit available to individuals to spread over several years the costs of an expensive medical episode. This approach encourages individual and family responsibility for medical bills, and in that way discourages unnecessary utilization of services. Loan guarantees by themselves may make financing available only to middle and upper income families who are in a position to repay the loans. States may choose to expand this financing plan to lower-income families through subsidies which reduce repayments to more manageable proportions, or which forgive the repayment of

portions of the loan depending on family income. This approach would encourage the sharing of uncompensated care costs between providers, beneficiaries, and State governments.

Regulatory Strategies

> Option: Encourage States to require employers to offer catastrophic coverage to employees and their dependents.

There are several ways in which States could mandate employment-related catastrophic coverage. One approach would require employers who currently offer health insurance to add a catastrophic insurance option. A second approach would extend the mandate to all employers, including those not now offering basic health coverage.

Either approach could be financed by the employer, the employee, or shared between the two. Obviously, the effectiveness of this mandate is enhanced by increased cost-sharing by the employer. Tax expenditures would increase, however, to the extent that employers pay the additional costs since those costs would be tax deductible. In addition, if employers were required to finance it, indirect costs could be substantial, which would come out of reductions in profits, employment and wages, and increases in product prices. These indirect costs also would be unevenly distributed. Since most workers who do not have insurance work in small firms and tend to be lower-wage workers, most of the burden would fall on them.

Option: Require individuals to purchase insurance.

Such an option would, by definition, expand coverage. Possible strategies include requiring proof of health insurance for school or college enrollment or for motor, vehicle registration. Any such strategy would target specific segments of the population and would be effective to the extent that costs of coverage are kept low. It could prove difficult to enforce to the extent that mandating an expenditure which has no direct relevance to the activity at hand is unpopular. Catastrophic health insurance requirements for drivers may be more easily justified than other mandates because of the risks of disabling injuries in traffic accidents. A high proportion of disabling injuries are caused by such accidents, and many of the victims receive substantial amounts of uncompensated care from hospitals and other providers. Requiring motor vehicle owners to share in the costs of those accidents through insurance is an appropriate response to a serious social problem. The cost of that insurance need not be high, if deductibles are set at levels that exclude noncatastrophic injuries and coverage is restricted to services provided only in connection with accidents. Also, it is already common practice in most casualty and indemnity policies written by automobile insurance underwriters.

CHAPTER SEVEN

MORE COMPLETE COVERAGE OF CATASTROPHIC ILLNESS EXPENSE FOR AMERICANS: RECOMMENDED STRATEGY

The American system for financing health care costs is a broad network of private insurance mechanisms and public programs which, together, protect the vast majority of persons from catastrophic out-of-pocket expenses when costly or prolonged illness strikes.

Of the general population, most are employed part or all of the time, or are dependents of someone who is employed. Most of these, in turn, are covered by employment-related group health insurance whose cost is borne, by employers as one component of the fringe benefit package. A large proportion of persons who do not work are covered for health expenses by Medicaid, a program designed to cover poor families with dependent children, the poor elderly, blind, and disabled. Of the elderly, virtually all are entitled to acute care coverage under Medicare. Most also have supplemental coverage in the form of policies bought in the private market.

The remaining risk for catastrophic acute illness out-of-pocket expenses comes from five sources:

- Elderly persons who have Medicare coverage but no supplemental insurance to fill in the gaps in Medicare.
- Elderly persons with supplementary coverage whose Medigap policy does not provide full catastrophic coverage.
- Persons in the general population whose acute care coverage does not

protect them fully from catastrophic illness expense.

- Persons in the general population who work for an employer who does not offer coverage.

- Persons in the general population who are uninsured because they do not work, are between jobs, are uninsurable for medical reasons, or are not eligible for Medicaid though they may have low incomes or be medically needy.

In addition to these gaps in catastrophic acute illness coverage, a major source of risk for catastrophic illness expenses comes from the need for long term personal care to help with activities of daily living in the event of chronic illness or disability. Most of the people at significant risk for catastrophic long term care expenses are elderly. Half of the dollar cost of long term care is paid by the elderly themselves. The other half is covered by Medicaid, for which many persons eventually become eligible because they have exhausted their financial resources on long term care expenses.

These gaps do not imply that persons are being denied essential care in this country, although some people do not receive needed care because they are not within geographic reach of a public hospital or clinic or have no insurance and therefore do not seek help. Where financing mechanisms fail, however, there can be great uncertainty about availability of care, and great personal hardship. Also, the costs of care will be borne in a haphazard way by the family, the provider (in the form of

charity or bad debt), and the taxpayer (through Federal, State, or local program expenditures).

It is important to note that coverage of catastrophic illness expenses by any mechanism does not eliminate these costs. Either it shifts them -- within the current population or to younger generations -- or it redistributes an individual's saving and spending patterns over that person's lifetime, so that financing is available for those expenses if and when they occur.

Substantial expansion of Federal programs is no panacea. In this era of fiscal stringency, such expansion -- unless covered by increased deductibles and coinsurance or the imposition of premiums -- could aggravate the deficit, raise taxes, and put the Medicare Trust Funds into even greater jeopardy. More generally, it could run the danger of stimulating unnecessary health care use. It would also increase Federal government control over what are now State, provider, and individual responsibilities for health care financing and use.

Our overall strategy recognizes the dangers of increasing public expenditures to increase catastrophic illness expense coverage. The recommendations, therefore, involve at most only modest net loss in tax revenues. The strategy also recognizes that much of what needs to be done can most appropriately be done through encouraging development of private financing mechanisms and increasing flexibility at the State and local levels.

As noted throughout the report the catastrophic illness expense problem consists of three components -- acute illness for

the elderly population, long term care in the event of chronic illness or disability, and acute illness for the general population. These components share an essential feature -- the threat presented by the risk of catastrophic out-of-pocket health care expenses to individuals or families' fiscal solvency, whatever the source of the threat.

ACUTE CARE CATASTROPHIC EXPENSE PROTECTION FOR THE ELDERLY

The Medicare program now has coverage gaps that leave the elderly with acute care needs vulnerable to catastrophic out-of-pocket expenses. This is an unnecessary defect of the program. A restructured Medicare program can promote equity among beneficiaries in a way that relieves the worries of the elderly about acute care expenses. At the same time the new structure can ensure that the elderly fully pay for this increased security, rather than depending on younger generations to finance it. Restructuring is consistent with efforts to increase competition and encourage capitated health care delivery. The recommendations presented here are also consistent with the cost-containment objectives of the President's 1988 budget.

PREFERRED RECOMMENDATION: Restructure Medicare to provide catastrophic protection with an actuarially sound additional premium.

This recommendation would place an annual limit on each beneficiary's out-of-pocket expenses for all Part A and Part B deductibles and coinsurance. Part A coinsurance and lifetime

limits would be removed, and the maximum number of hospital deductibles would be two per year. Part B cost-sharing arrangements would remain unchanged. Catastrophic coverage with a $2,000 annual limit would require an additional annual premium of $59. That additional cost would be included in the Part B premium, which would remain voluntary.

The current structure of the Medicare program requires the beneficiaries most in need of services to pay potentially catastrophic costs. Restructuring the Medicare program as recommended sets limits on the out-of-pocket expenses to protect the minority of persons who experience catastrophically expensive illness. It also spreads the costs of those high expenses equitably across beneficiaries. Thirty million participants in the Part B program would receive protection from the possibility of devastating medical costs for $4.92 extra a month -- a very modest price to pay for increasing the elderly's peace of mind.

The low premium results from spreading the costs of catastrophic events across a large number of people. Moreover, overhead costs would be minimal because Medicare's administrative operations can easily handle this modification. No expansion of government bureaucracy would be required to implement the recommendation. Both elements contribute to the ability of this recommended approach to provide catastrophic coverage for the greatest number of elderly at the lowest possible cost to the consumer.

This recommendation requires that the benefit be fully funded by the premium, which would be indexed to insure that no subsidies out of general tax revenues are required. Indexing assures that the tax burden of the working age population is not increased, and that those who receive the benefit pay their fair share of the cost. Such an automatic mechanism is required to avoid expanding the Medicare program budget.

The elderly will readily embrace this restructure of benefits for several reasons. Perhaps more important than the reasonable cost is the faith the elderly have in the Medicare program. A sound restructure will be accepted to a large extent because of this faith -- which places even greater emphasis on responsible legislation. Moreover, beneficiaries will be attracted to the simplicity of premium payments. Their predictability makes budgeting for them straightforward. In addition, simplifying medical benefits will add considerably to the certainty with which beneficiaries can make financial plans. Although the catastrophic benefit would be voluntary, a condition of participating in the Part B program, these facts suggest that all but a fraction of a percent of those now electing Part B coverage would elect the modified program.

The recommended premium approach to restructuring does not diminish private sector involvement in the operation of the Medicare system. Medicare will continue to work through private insurers to process claims and use mechanisms already in place to maintain the quality of our elderly's health care. In addition,

private Medigap insurers will continue to fulfill an important role by offering supplementary coverage for coinsurance and deductibles that will remain a feature of the restructured Medicare program.

Finally, restructuring Medicare will have positive effects on the Medicaid program. Acute care catastrophic coverage for beneficiaries will lead to fewer persons using up their personal resources for extraordinary expenses and spending down to Medicaid eligibility. And States will find it advantageous to buy-in to provide cost-effective protection for their poor elderly.

ALTERNATIVE RECOMMENDATION 1: Restructure Medicare to provide catastrophic protection with increased cost sharing related to income.

ALTERNATIVE RECOMMENDATION 2: Restructure Medicare to include catastrophic coverage with increased cost sharing unrelated to income.

These alternative recommendations finance catastrophic protection under Medicare by shifting coverage away from initial health care costs to pay for extremely high annual costs. There are numerous ways to implement this type of restructuring. For example, for a payment structure not related to income, catastrophic coverage with a $2,000 annual limit on each beneficiary's out-of-pocket expenses and limiting the $520 Part A hospital deductible to no more than twice per year would require the following new coinsurance: inpatient hospital coinsurance of

$10 per day for days 2 through 11; skilled nursing facility (SNF) coinsurance of 10 percent of the average daily cost of care, for up to 100 days of care; home health coinsurance of 10 percent of the average visit cost, for up to 100 visits; an increase in the Part B deductible from $75 to $170. As with the premium recommendation, the coinsurance would be indexed to keep pace with medical service cost increases.

If a payment structure is preferred that relates coinsurance rates to beneficiary income, one alternative is to keep the Part B coinsurances the same (indexed for cost increases) for the beneficiaries whose incomes are below a certain threshold -- the level at which Social Security benefits start to be taxed is an illustrative example -- and charge higher income beneficiaries additional copayments calculated to cover the total cost of the increased coverage. This is the first time that cost sharing related to income has been recommended for the Medicare program. However, it is not an unprecedented change for the elderly population on Social Security because income-related cost sharing was introduced into the OASDI program in 1983.

The strength of this proposal is that it provides catastrophic coverage to all Medicare beneficiaries, not just to those who choose to participate in Part B. Its main weakness is that the cost is borne only by those who use the system -- a tax on the cost of illness.

* * *

An option for providing catastrophic protection within the context of the Medicare program, which was carefully considered, would be implementation of an IMA in the form of a refundable tax credit for savings used to buy post-retirement health insurance. In return for receiving the tax subsidy, beneficiaries would pay higher deductibles under Medicare, based actuarially on the amount saved by the time they became eligible for Medicare. This broader proposal was not recommended here because it is targeted at longer-run problems facing Medicare. These are separate from the issue of catastrophic protection and require attention in their own right.

A second option that received detailed consideration was to modify Medigap insurance regulations to mandate that all Medigap policies contain catastrophic coverage, and that Medigap carriers also offer a low-cost catastrophic-only option. Approximately 65 percent of aged Medicare beneficiaries have some type of supplemental private insurance in addition to Medicare. This option would require, through Federal mandate and accompanying State regulations, that carriers of Medicare supplemental policies offer catastrophic health care coverage. This is a private sector approach that would benefit a high proportion of the elderly.

Medigap regulatory change was ultimately rejected for several reasons. First, the cost to the beneficiary would be higher than under the restructure approach -- even for the

catastrophic-only policy, because of the relatively low pay-out rates for private insurance compared to the Medicare program. Second, the new policies could be confusing to the elderly, and burdensome to providers. This is a problem that results from the wide variation of insurance benefits and costs in the marketplace. This could cause increased Federal and State regulatory and enforcement activities. Finally, catastrophic coverage would not be immediate, as it would take time for the insurance market to reach the majority of beneficiaries.

LONG TERM CARE PROTECTION ALTERNATIVES

Long term care is the most likely catastrophic illness risk faced by individuals and families. There are several reasons for this. Foremost among them is the enormous ignorance on the part of many people about the financial risk they run in the event that they need long term care. Part of this is misunderstanding about the coverage available under Medicare and supplementary Medigap insurance. Part of it is lack of appreciation of the possible need for care in old age. The result is lack of demand for long term care risk protection and consequently only modest progress in developing alternatives for effective private sector long term financing and service provision.

Our strategy for addressing the long term care problem is guided by four considerations. First, Americans should be encouraged to make adequate plans for their own care in old age. Second, the financing of long term care should not inhibit

maximum choice regarding the types and level of care. Third, the elderly prefer and should be able to receive the least restrictive care possible. Thus, approaches should be emphasized that allow people to remain in their own homes, or in facilities that meet multiple personal and medical needs, such as church homes and Continuing Care Retirement Communities. Fourth, the public sector is already paying half the costs of formal long term care through Medicaid.

The specific set of recommendations for long term care includes improving the knowledge and understanding of Americans regarding the risk of needing long term care and the options for financing it. It includes, further, inducements for private saving to cover long term care needs and measures to stimulate the offering of adequate long term care insurance on the private market.

RECOMMENDATION: Work with the private sector to educate the public about the risks, costs, and financing options available for long term care, as well as the limitations of coverage for such service under Medicare and Medigap supplemental insurance.

Recent surveys have shown that consumers generally fail to recognize their need for financial protection for the potentially catastrophic costs of long term care. Typically, individuals tend to deny that the risk of catastrophic expenses exists. To the extent that they recognize the risks, most elderly persons and their families incorrectly assume that Medicare or private Medigap policies provide adequate protection.

The Department of Health and Human Services (HHS) has taken this excellent opportunity to lead and coordinate an organized public education campaign in cooperation with other interested public and private sector organizations, State and local governments, and industry associations. The Report of the National Association of Insurance Commissioners and the HHS Task Force on Long Term Health Care Insurance policies will provide further direction in implementing an education campaign.

The elements of a campaign might include:

- Use of radio, television, and printed material targeted to both the elderly and their families, providing information regarding risks, costs, and financial protection measures.
- Use of official mailings to Social Security and Medicare beneficiaries to clarify current program coverage for long term care services.
- National coordination of and assistance for State-led efforts to assist consumers in understanding and selecting financial protection for long term care services.
- Educational and promotional efforts on private financing of long term care directed toward long term care insurers and providers.

This recommendation would have a far-reaching impact on the nation's elderly and their families. Today's elderly will have a better understanding of their health care coverage limitations under Medicare and supplemental Medigap coverage. Future generations of retirees, with full knowledge of their Medicare benefits, will be able to plan their resources in case of need for long term care services. In addition, at minimal cost to the Federal government, the private sector, through the insurance

industry and employers, has innumerable opportunities for implementing an education program. A joint public and private effort such as this would provide convincing evidence to the public of the need for long term care protection and would present the array of private sector alternatives that are being developed and becoming available for such protection.

RECOMMENDATION: Encourage personal savings for long term care through a tax-favored Individual Medical Account (IMA) combined with insurance, and amend Individual Retirement Account (IRA) provisions to permit tax-free withdrawal of funds for any long term care expense.

The first part of this recommendation uses tax-favored individual savings to encourage personal responsibility to pay for long term care expenditures. An IMA promotes private financing of long term care expenses through tax-favored savings combined with insurance. Individuals would be permitted to deposit a certain amount of money (e.g. $1,000 maximum) each year into a savings account restricted for use on long term care expenses. Interest accumulations would be tax free and withdrawals would not be taxed or penalized as long as their use was for nursing home care. The principal and half the interest could be used by the individual to pay for nursing home expenses incurred after age 65; if unused it would remain in the individual's estate. The remainder of the interest would be used to finance additional nursing home expenses for IMA holders after the balance in their personal accounts had been exhausted.

Savings limits would be set to cover up to two years in a nursing home for those saving at the maximum rate for a specified number of years. Coverage from the pool would be reduced proportionately for persons choosing to save less than the maximum or for a shorter period. A person saving $1,000 a year (indexed for inflation) from age 40 until age 64 would be entitled to nursing home care at a rate of $50 a day (also indexed) for 25 months. The vast majority (82 percent) of current nursing home stays are no longer than this and most are shorter.

The major strengths of this part of the recommendation are that it encourages personal responsibility for long term care needs and enhances private sector involvement in financing those needs. This strategy offers participants more months of protection than savings-only plans because of the cost sharing feature of risk pools.

The second part of the recommendation -- tax-free withdrawal of IRA funds for any long term care expense -- provides the opportunity to finance a full range of care that would allow individuals to remain in the least restrictive environment possible. For example, a person saving $1,000 a year (indexed for inflation) from age 40 to age 64 could cover 16 months of nursing home care, or use the equivalent dollars for purchasing a wide range of community-based services.

The major strength of this part of the recommendation is that it builds on an existing tax-favored savings mechanism. It allows persons to save for long term care expenses, while

offering substantial flexibility and choice in purchasing financial protection or services. Encouraging individuals to save will help stimulate the necessary demand to promote development of long term care insurance and other private financing mechanisms, more so than with a pure long term care insurance approach.

This recommendation encourages individuals to reevaluate lifetime savings and consumption patterns to reflect the fact that now, more than ever, we are likely to have 20 years after retirement when we need to take care of ourselves. This, in turn, should reduce the pressure on the Medicaid program and allow States flexibility in meeting the needs of nursing home residents on Medicaid in a more humane fashion.

RECOMMENDATION: Encourage development of the private market for long term care insurance in three ways:

- **establish a 50 percent refundable tax credit for long term care insurance premiums for persons over age 55 (up to an annual maximum of $100);**
- **provide the same favorable tax treatment for long term care insurance reserves as is now the case for life insurance;**
- **remove 1984 DEFRA barriers to prefunding long term care benefits provided by employers to retirees.**

The major strength of this three-part recommendation is its potential for stimulating of demand for private long term care insurance and for broadening the market for such policies -- including innovative products that combine income and health

benefits for individuals in their retirement years, and individual freedom to receive the care they need in the least restrictive living environment. It is an important complement to the education campaign recommended above, which would increase awareness of the need for long term care insurance and begin the process of stimulating demand for it.

The specific reason for establishing the refundable tax credit is to give a direct incentive for potential buyers, stimulated by their increased awareness of the risks, to take action. This incentive would be attractive to lower-income families. The specific reason for the recommended treatment of reserves is that long term care insurance involves accumulation of reserves over a much longer period than is necessary for acute health care coverage. Providing favorable tax treatment would encourage development of more affordable long term care insurance policies. Removal of the DEFRA barriers is a necessary prerequisite for a gradual development of employment-based group coverage of long term care.

The combination of incentives will encourage the development of more flexible private insurance coverage, including home care, case-managed social and medical services under capitation, and different types of protected living environments where the elderly can receive services appropriate to their needs.

The budgetary implications of this recommendation in the short run are extremely modest because the market is just beginning to develop. In the more distant future, the

implications, particularly of the tax-favored treatment of interest on reserves, could be substantial.

RECOMMENDATION: The Federal government set an example for private employers and care providers offering employee-paid long term care group insurance as an option under the Federal Employees Health Benefit Program.

The Federal government is the nation's largest employer. Its leadership role could be valuable in demonstrating the effectiveness of using large groups as a vehicle for offering long term care coverage to retirees at lower cost, at group rates, and to younger employees. The Office of Personnel Management has expressed an interest in exploring opportunities to establish such an option for Federal employees.

Retirees might be given a choice of paying separately for long term care insurance or of trading some of the health insurance benefits currently offered for better long term care insurance coverage. Although long term care policies are not currently available to persons in their middle years, it is possible that interest in creating such policies would be generated if a large pool of individuals were available.

CATASTROPHIC PROTECTION FOR THE GENERAL POPULATION

The general population includes many specific groups with differing coverage availability and coverage needs. Most of the general population are employed or dependents of an employed worker. Their protection typically comes from employment-related

insurance, whether self-financed or as part of a fringe benefit package. Employers must have new incentives to expand private sector benefits to include catastrophic coverage alternatives. Historically, coverage of the poor, the near poor, and the related problem of uncompensated care have been the responsibility of State and local governments. This should continue. However, such governments need increased flexibility to develop a wider choice of alternative ways of meeting these coverage needs.

RECOMMENDATION: States require that catastrophic coverage be offered in all employment-related coverage.

The vast majority of people under the age of 65 are covered by employment-related coverage. Of those with coverage, however, almost 7 1/2 million are at risk for incurring catastrophic expense -- the so-called underinsured. State mandates would require only employers who offer health insurance to include a catastrophic option, either as part of a comprehensive plan or as a separate option. This would allow employees an opportunity to purchase catastrophic coverage for a modest insurance premium since catastrophic coverage per se is not very expensive.

The mandate would not require that employers contribute to the financing of the coverage. While it is important for States to extend an opportunity for catastrophic coverage to those with inadequate insurance, it is equally important that this additional protection not represent an increased cost to employers unless they choose to cover it. Imposing the cost of

coverage on employers would add to production costs and could lead to higher prices paid by consumers, lost jobs and lower wages, and a reduction in international competitiveness. It is critical to not raise employer health costs just as American industry is beginning to correct the imbalances and excesses that contributed to the economic malaise of the late 1970s. The cost of family catastrophic coverage is not high, ranging from $200 to $600 per year, although some people might be deterred by even this additional cost.

RECOMMENDATION: Extend full tax deductions for health insurance to the self-employed and unincorporated businesses, as long as coverage is included for catastrophic expenses.

Until the recent tax legislation, the self-employed and owners of unincorporated businesses could not deduct the premiums for their own health business plans. This has not only meant that the self-employed and owners of unincorporated businesses are less likely to be covered by health insurance, but also that their employees are less likely to be covered as well. With the recent legislative change, the self-employed can now deduct 25 percent of their premiums. While this will help, there is little justification for not allowing certain limited portions of the employed population the same tax subsidies available to the rest of working population. The extension of the full tax subsidy should require that the self-employed and unincorporated business owners offer comparable coverage to their employees and that the coverage include catastrophic expenses.

Little is known about the insurance coverage of people working in unincorporated businesses. However, we do know that most of those affected would be very small businesses, including a large number of farmers. The cost of this program occurs as revenue loss to the Federal Treasury. The more effective the stimulus, the greater the cost to the Treasury; but the reduction in health expense of the uninsured will be greater also.

RECOMMENDATION: Encourage the formation of State risk pools to subsidize insurance for those whose medical condition makes it impossible or prohibitively expensive to get insurance.

The formation of high risk pools for the medically uninsurable is an increasingly popular concept which has already been adopted in six States and is under consideration in a number of others. States can and do structure these pools in a variety of ways. Some States require that individuals be turned down for insurance or have a specified illness; but the goal of directing the insurance to the medically uninsurable could also be accomplished by setting the rate at a high enough premium -- for example 150 percent of the average small group premium -- to deter those who can buy insurance on the private market. Setting the premium rate of 150 percent of small group rates or other rate regarded as affordable will require a subsidy. The subsidy should be spread over some large group -- either taxpayers or the insurer/employer community.

Use of an insurance pool for high risk individuals can be an

effective way of reaching this very small but medically and financially vulnerable population.

RECOMMENDATION: Encourage state innovation and initiative in such areas as loan guarantees, high-deductible catastrophic health insurance requirements for motor vehicle registrations, and greater flexibility in managing State Medicaid programs.

The catastrophic health insurance needs of persons with employment-related coverage and persons who are medically uninsurable or insurable only at very high cost have already been addressed in our recommendations. Other groups in the population can be helped substantially by the States. Understanding of the State and local environment can enable States to foster catastrophic health insurance in innovative ways which target particularly vulnerable groups.

States could, for example, institute a loan guarantee program for persons incurring high health expenses. Loan guarantees would make credit available to individuals to spread the costs of an expensive medical episode over several years. This approach encourages individual and family responsibility for medical bills, and in that way discourages unnecessary utilization of services. Loan guarantees, coupled with possible State subsidies to broaden the program to lower-income families, would encourage the sharing of uncompensated care costs between providers, beneficiaries, and State governments.

Another approach is for States to target specific activities or groups of people for catastrophic health insurance coverage. States could, for example, require accident-related catastrophic

health insurance for all motor vehicle registrations. Driving accidents can cause disabling injuries, and many of the victims receive substantial amounts of uncompensated care from hospitals and other providers. Requiring motor vehicle owners to share in the costs of these accidents through insurance is an appropriate response to a serious social problem.

A third avenue for State innovation is in the management of their Medicaid programs. This option would encourage States to use existing resources in developing programs tailored to meet local needs and preferences for dealing with catastrophic expenses. Among the wide range of possibilities are inclusion of catastrophic benefits as a category of service; shifting coverage toward catastrophic expenses and away from optional services; waiving income determination rules to secure family contributions toward institutional care; and other modifications to State Medicaid programs.

States have proven their ability to meet State and local health care needs in a cost-effective manner. Under the existing Medicaid Home and Community-based Waiver Program, for example, states have availed themselves of a wide range of services for their people that would not otherwise be covered under Medicaid. Many of these services (e.g. respite care and transportation services) are geared to persons with chronic, high-cost ailments. Further, a number of States have taken the initiative in finding new ways to finance health care for the poor. For example, Florida has instituted a hospital bed tax to subsidize an

expansion of its Medicaid program. Some states have used the Medicaid Model Waiver Program to ensure eligibility for catastrophically ill persons such as technology-dependent children.

Conclusion

The threat of catastrophic illness is very real. Now is the time, after decades of debate, to forge a partnership between government and the private sector which will help provide coverage for catastrophic illness expense.

Risk of catastrophic illness expense faces persons and families in a wide variety of economic and personal circumstances. A wide range of public and private coverage already exists. This diversity suggests the need for a variety of approaches involving every segment of employers, providers, insurers, all levels of government, and most importantly, individuals and their families. Approaches must address the preservation of individual choice and individual responsibility at the same time that they make provision for the financing of needed services.

Private sector initiative and responsible government action can lead to a strengthened health care system and the ultimate resolution of this important problem. Failure to act now will not make the problem disappear. Indeed, delay may make it harder to solve as the population ages.